

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05077

CERTIFICATE OF DEATH

05075

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

16 WEEKS

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

JACKSON CONVALESCENT HOME

3. NAME OF
DECEASED
(Type or Print)

First

Middle

BERTHA

MAE

ANGLE

5. SEX

6. COLOR OR RACE

FEMALE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOME MAKER

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years last birthday)

10b. KIND OF BUSINESS OR INDUSTRY

10c. BIRTHPLACE (County & State, or foreign country)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

COMMODORE F LOWMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

NONE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4-500 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Generalized arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH
3 years

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour e.m. 20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-25-61, 19....., death, 19....., that (I) (we) last saw the deceased alive on 4-1-62, 19....., and that death occurred at 10 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Paul Harrison
(Robert F. Keadle) ---/RFK M.D.22b. DATE
SIGNED
4-4-6222c. PHYSICIAN'S
NAME (Type)

PAUL HARRISON M. D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

318 N POTOMAC ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

4-6-62

23b. DATE THEREOF

ROSE HILL CEMETERY

23d. LOCATION (City, town or county) (State)

HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

Charles Rouzer

SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

APR 10 '62

Charles S. Thorne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film 0312 5/8/62 iwk

05076

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

Month

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Western Md. State Hosp.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

CHARLES

Otha

BAGENT

1888

March

29

1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

WIDOWED

DIVORCED

NEVER MARRIED

</



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05079

CERTIFICATE OF DEATH

05077

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

7 Months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Western Md. State Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

SUSAN

BARBER

4. SEX

Female

White

6. COLOR OR RACE

WIDOWED

DIVORCED

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

July 4, 1874

9. AGE (In years
last birthday
yrs.)4. DATE
OF
DEATH

APRIL

5

28

1962

Month

Day

Year

e. IS RESIDENCE
ON A FARM?
YES NO 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Adams Co. Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Leonard Wyssinger

14. MOTHER'S MAIDEN NAME

Mary Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Simon Summers

Address

Hag. Rt. 5

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

ANEURISM OF THE ABDOMINAL AORTA - RUPTURED FEW HOURS

451X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

GENERALIZED ATHEROSCLEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

UNKNOWN

2. MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
SUBACUTE AND CHRONIC PYELONEPHRITIS PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

e.m.

p.m.

19

20d. INJURY OCCURRED

While Not While

at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-19-1961 to 4-28-1962, that (I) (we) last
saw the deceased alive on 4-28-1962, and that death occurred at 8:30 AM, from the causes and on the date stated above.

22e. SIGNATURE

Antonio U. Pallagrosi

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. *Dr. Antonio U. Pallagrosi* DATE SIGNED
By myself

22c. PHYSICIAN'S NAME

ANTONIO U. PALLAGROSI

22d. ADDRESS

1500 Pa Ave Hagerstown Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

5-1-62

23c. NAME OF CEMETERY OR CREMATORI

Shiloh U. B. Cemetery Fiddlersburg. Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son Hagerstown, Md.

ADDRESS

25a. REC'D BY REGISTRAR

DATE MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

27

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05080

CERTIFICATE OF DEATH

05078

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician, then please remove carbon papers. Pages 1 and 2 should be filled in with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CHEWESVILLE

c. LENGTH OF STAY IN 1b

18 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

NO STREET ADDRESS

3. NAME OF DECEASED
(Type or print)First
LILLIEMiddle
SEIBERTLast
BECK4. DATE
OF
DEATH

APRIL

4

1962

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

 NEVER MARRIED

8. DATE OF BIRTH

AUGUST 31 1872

9. AGE (In years
last birthday)

89

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

HOME MAKER

FRANKLIN PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

CONRAD SEIBERT

BARBARA FRIESE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS JOHN W CABLE JR CHEWESVILLE MARYLAND

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pneumonitis

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Conditions, if any, which
gave rise to immediate cause{ (e), stating the underlying
cause last.

DUE TO

(b) Arteriosclerotic Cardio Vascular Disease

10 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3-1-1962 to 4-1-1962, that (I) (we) last saw the deceased alive on 4-3-1962, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
APRIL 6 196222c. PHYSICIAN'S
NAME (Type)

E.W. DITTO JR. M.D.

22d. ADDRESS

215 W. WASHINGTON ST. HAGERSTOWN MARYLAND

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF
4-6-6223c. NAME OF CEMETERY OR CREMATORIUM
REST HAVEN CEMETERY

23d. LOCATION (City, town or county)

(State)

HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 10 '62

Ciribus S. Diana

090

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05081

CERTIFICATE OF DEATH

05079

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

10 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Western Md. State Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Arvlee

Bridges

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 27, 1881

4. DATE
OF
DEATH

Last Month Day Year

April 14, 1962

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

Buildings

11. BIRTHPLACE (County & State, or foreign country)

Campbell Co., Tenn.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William H. Bridges

Catherine Foust

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or date of service)

No

214-16-1484

Address

Mr. Ollie Bridges, New Market, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Lobular Pneumonia, bilateral

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

cerebro-vascular accident

9 years

DUE TO
(b)

general arteriosclerosis

20 years

DUE TO
(c)PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 1920d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (his hospital) attended the deceased from April 5, 1962 to April 14, 1962 that (I) (we) last
saw the deceased alive on April 14, 1962, and that death occurred at 9:15 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Victor L. Pamos, M.D.

22c. PHYSICIAN'S
NAME (Type)ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS. April 14, 1962
SIGNED23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial23b. DATE THEREOF
4/17/6223c. NAME OF CEMETERY OR CREMATORIUM
Montgomery Meth.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Olin L. Wobsmuth

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Damascus, Md.

Clagettsville, Md.

DATE APR 18 '62

Victor L. Pamos

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

VR A15 (4)
1SM 7/61



1
FOR STATE
HEALTH DEPT.

M

TO DEATH
Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05080

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

57 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEDERED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

Dec. 29, 1897

9. AGE (In years
last birthday)

64

Yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Retail Store

11. BIRTHPLACE (State or foreign country)

White Post, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Albert Carper

14. MOTHER'S MAIDEN NAME

Elizabeth Grubbs

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-09-0805 Mrs. Dorothea C. Carper Hag. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Occlusion

DUE TO

Pulmonary Congestion & Edema

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Coronary Atherosclerosis, Severe

DUE TO

(c)

Cardiac Hypertrophy

INTERVAL BETWEEN
ONSET AND DEATH

Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

a.m.

p.m.

While
at work

Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Dr. E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 14, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4-16-62

22c. NAME OF CEMETERY OR CREMATORI

Rose Hill Cemetery

22d. LOCATION (City, town, or country)

Hagerstown, Md.

(State)

23. FUNERAL DIRECTOR

ADDRESS

Scott F. Minnich & Son Hagerstown, Md.

24a. REC'D BY REGISTRAR

DATE APR 17 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05083

CERTIFICATE OF DEATH

05081

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

MARYLAND

4 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wash County Hospital

First

Middle

3. NAME OF DECEASED
(Type or print)

GEORGE

ELVIN

CONDON

5. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

13. FATHER'S NAME

William Condon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

705-10-5886

17. INFORMANT

Mrs Pauline V. Condon 357 Ridge Ave

Address

Hagerstown Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).

2. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).

3. DUE TO

4. DUE TO

5. DUE TO

chronic lymphocytic leukemia

INTERVAL BETWEEN
ONSET AND DEATH

2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a. 19. WAS AUTOPSY PERFORMED?

① general arteriosclerosis - ② prostate hypertrophy, benign YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

White Not White

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from June 28, 1960 to Apr. 23, 1962 that (I) (we) last saw the deceased alive on Apr. 22, 1962 and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Edward W. Dittto

M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Edward W. Dittto 111, L.D.

22d. ADDRESS

217 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 4/26/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Rest Haven Cemetery

23d. LOCATION (City, town or county)

Hagerstown Wash Co Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

ADDRESS

25a. REC'D BY REGISTRAR

APR 26 '62

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

1

M

I

VR A15 [4]

15M 7/61



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05084

05082

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

Mary

Hetzer

Downey

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Aug. 2 1885

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Park Head Maryland

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Charles Hetzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank, dates of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mr. George B. Downey

Sharpsburg Pike
Hagerstown RFD 3

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Traumatic Ruptures, (Two) First Part Of Jejunum

816 X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Acute Generalized Peritonitis

DUE TO Multiple Bony Fractures: Left Ilium Right

(c) Patella

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, if item 18)

In collision with another car Sharpsburg Pike 1 mile South Of

Fagerstown

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County)

7:30 p.m.

1-28-62

19

While at work

Not While at work

At work

Not at work

Sharpsburg Pike Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

E. W. Ditto, Jr.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

May 1, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) 22d. LOCATION (City, town, or country) (State)

Burial

May 2-62

Rose Hill Cemetery

Hagerstown Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

Albert Leaf Williamsport, Md.

DATE MAY 3 '62

Clarice S. Kline

TO D 1 MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If over 24 hours, give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.
VS. A15ME
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 days may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05085

CERTIFICATE OF DEATH

05083

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 16

5 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Marbern Road

3. NAME OF
DECEASED
(Type or print)

First

Middle

ROY

MADISON

Last

4. DATE
OF
DEATH

Month April 29 1962

5. SEX

6. COLOR OR RACE

male white

7. MARRIED NEVER MARRIED

W DOWED DIVORCED

8. DATE OF BIRTH

September 30, 1876

9. AGE (In years
last birthday)

85 yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Ret. Carpenter self employed

Frederick Co. Md.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Martin V. Easterday

Susan Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.: 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or dates of service)

no

214-09-3826 Mrs. Margaret Ruth, Hagerstown, Md.

Address
Marbern Road
Hagerstown, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

692.4

DU TO

Cachexia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DU TO

Abscesses, multiple, right leg

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arteriosclerotic heart disease, cerebral arteriosclerosis

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

p.m.

19

While
at work

Not While
at work

21. I certify that (I) (this hospital) attended the deceased from 2-24-62 to 19 death, 19, that (I) (we) last
saw the deceased alive on 4-28-62 and that death occurred at 6:00 AM from the causes and on the date stated above.

22a. SIGNATURE

Robert F. Keadle

M.D.

ATTENDING
PHYS.

MED
DIRECTOR

STAFF
PHYS.

4-30-62

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

Robert F. Keadle

318 North Potomac Street, Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

Rest Haven

23d. LOCATION (City, town or county)

(State)

Hagerstown Wash. Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

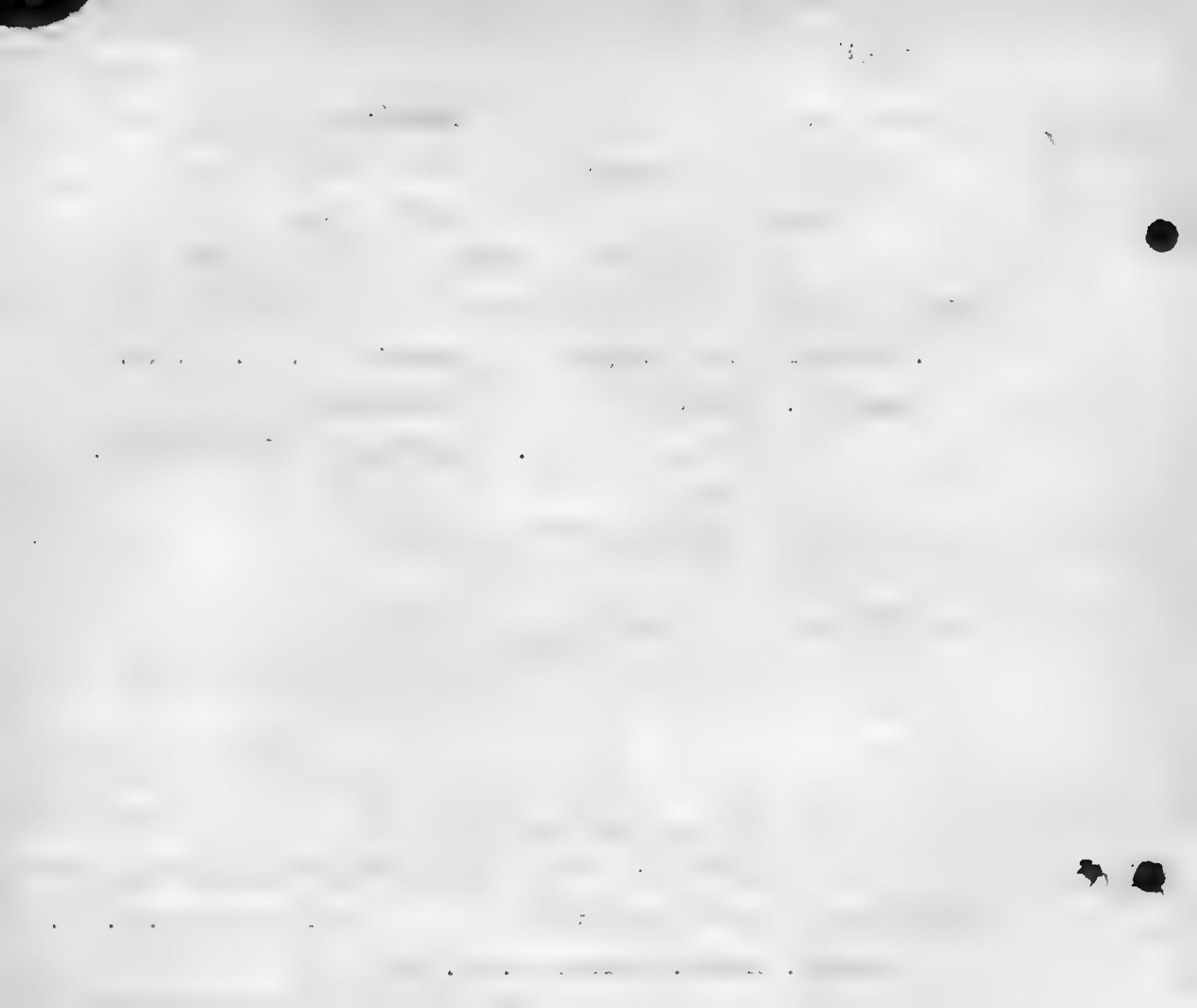
Paul F. Bittle, Myersville, Md.

25a. REC'D BY REGISTRAR

MAY 2 '62

25b. REGISTRAR'S SIGNATURE

Clinton J. Pearce



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05084

1 M

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ROHRERSVILLE

c. LENGTH OF STAY IN lb

754 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

MAIN ST

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

MARYLAND

b. COUNTY

WASHINGTON

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

MAIN ST.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECESSED
(Type or print)

ALBERTA

4. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

FEMALE

WHITE

WIDOWED DIVORCED

EASTON

FEBRUARY 9, 1877

9. AGE (in years
last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. HOUSE WIFE

10c. OWN HOME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give where or dates of service)

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

+50.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.NONE MRS. G. ROVER DORMAN HAGERSTOWN MD. R. 3
Generalized arteriosclerosis
Procedure of urologyINTERVAL BETWEEN
ONSET AND DEATH

5 yrs.

1 mo.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING

CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

p.m.

19

While at work Not While at work 21. I certify that (I) (this hospital) attended the deceased from Oct 10, 1961 to 4-4-1961, that (I) (we) last
saw the deceased alive on 4-2-1962, and that death occurred at 11 P.M. from the causes and on the date stated above.

22e. SIGNATURE

G. W. LeDare

M.D.

4/6/62 DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

APRIL 7, 1962

23c. NAME OF CEMETERY OR CREMATORIUM

ROHRERSVILLE CEMETERY

24 FUNERAL DIRECTOR'S SIGNATURE

John H. East

ADDRESS

Boonsboro MD.

DATE APR 11 '62

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

John H. East

Boonsboro MD.

DATE APR 11 '62

John H. East

Boonsboro MD.

DATE APR 11 '62

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Boonsboro MD.

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DATE APR 11 '62

John H. East

Boonsboro MD.

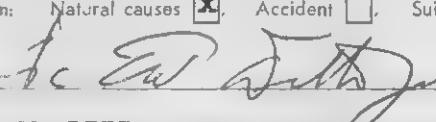
DATE APR 11 '62



DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 640 Summit Ave.		d. STREET ADDRESS Hagerstown	
3. NAME OF DECEASED (Type or print) Lewis Markell		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. DATE OF BIRTH Eberly Feb. 16, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
13. FATHER'S NAME Frank Eberly		14. MOTHER'S MAIDEN NAME Norma Jean Neff Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 17. INFORMANT	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 511.0		Frank Eberly Hagerstown, Md.	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		INTERSTITIAL PNEUMONIA	
DUE TO (c)		Pulmonary congestion and edema	
DUE TO (c)		Gastro-enteritis, nonspecific	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) E. W. DITTO, JR., M. D.		DATE SIGNED 4-30-62	
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 4-30-62	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or country) Hagerstown, Md.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son Hagerstown, Md.		24a. REC'D BY REGISTRAR MAY 2 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05088

CERTIFICATE OF DEATH

Reg. Dist. No. 05086

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

M

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MYERSVILLE		d. STREET ADDRESS 16 X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RICHARD	Middle E.	Last FRANKLIN	4. DATE OF DEATH	Month 4	Day 1	Year 1962
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1884	9. AGE (in years last birthday) 77	10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) WASHINGTON COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Downs				14. MOTHER'S MAIDEN NAME Anna R. Pierce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT HOWARD L. DOWNES		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 4 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from alive on 4/1 1962		3/12 1962		4/1 1962		4:15 PM	
ACTUAL SIGNATURE <i>Jacob G. Warden</i>		ADDRESS (Street, city or town, state) 832 POTOMAC AVE.					
PHYSICIAN'S NAME (Type) JACOB G. WARDEN, M.D.		DATE SIGNED —					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1 1962		22c. NAME OF CEMETERY OR CREMATORIAL Frontsville Cem.		22d. LOCATION (City, town, or county) Frontsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. P. Konkans Meyersdale, Pa.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 9 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Miller</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05088

CERTIFICATE OF DEATH

05087

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Williamsport

MARYLAND

c. LENGTH OF STAY IN lb

10 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Holewood Church Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

LAURA ELLEN FUNK

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

January 16, 1866

9. AGE (In years
last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

St. James Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Solomon Funk

14. MOTHER'S MAIDEN NAME

Catherine Rowland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Williamsport, Md.
House Work Records,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

22

DE TO

(b)

DE TO

(c)

Cerebral Hemorrhage

Cerebral Arteriosclerosis

General arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

1 yr

Yes

No

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AS UTOPIA PERFORMED?

YES NO

19. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from ... Aug. 1960 to ... Apr. 1962, that (I) last saw the deceased alive on ... 1962, and that death occurred at ... M., from the causes and on the date stated above.

22e. SIGNATURE

22f. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/26/62

23c. NAME OF CEMETERY OR CREMATORI

Zion E&R Cemetery

23d. LOCATION (City, town or county)

Hagerstown, Maryland.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman, Hagerstown, Maryland.

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

APR 26 '62

Arthur S. Kraus

22

VR A15 (4)
1SM 7/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05090

05088

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Western Maryland State Hospital

3. NAME OF
DECESSED
(Type or print)Joseph
Male

First

Middle

Last

4. DATE
OF
DEATHMonth
4Day
20Year
1962

5. SEX

6. COLOR OR RACE
Male Negro7. MARRIED
8. NEVER MARRIED

9. B. DATE OF BIRTH

January 1, 1904

10. a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Oysterman (Waterman) Oyster Business

11. BIRTHPLACE (County & State, or foreign country)

Charles County, Maryland U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Goosberry

Mary Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

213-16-2823 Mrs. Margaret E. Goosberry-Wife-Rock Point, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)150X
Condition if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Carcinoma of esophagus

INTERVAL BETWEEN
ONSET AND DEATH

one year 4 months

19. WAS AN AUTOPSY PERFORMED? YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OP CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of Item 18.

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 29, 1962 to April 20, 1962 that (I) (we) last
saw the deceased alive on April 20, 1962 and that death occurred at 8:20 A.M. from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION, OR
REMOVAL (Specify)

Burial 4/24/1962

23b. DATE THEREOF

4/24/1962

23c. NAME OF CEMETERY OR CREMATORI

Holy Ghost Cemetery

23d. LOCATION (City, town or county)
Penna Ave Hagerstown Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arehart Funeral Home, Inc.

La Plata, Md.

15M 7 61

25a. REC'D BY REGISTRAR APR 25 '62

25b. REG STRR'S SIGNATURE

Arthur J. Arehart

Arehart Funeral Home, Inc.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05091

CERTIFICATE OF DEATH

05089

1
M
R. LEVAN
BX1. PLACE OF DEATH
a. COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

FAKLES MILL 10 YEARS

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

KEEDYSVILLE MD. R.I.
First Middle3. NAME OF
DECEASED
(Type or print)

ADAM

E. GREEK

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

WIDOWED

8. DATE OF BIRTH

DIVORCED

9. AGE (in years
last birthday)

JANUARY 2 1892

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State, or foreign country,

13. FATHER'S NAME
RETIRED FARM LABORER14. MOTHER'S MAIDEN NAME
SAMUEL GREEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(b)DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 1920d. INJURY OCCURRED
While Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Hour a.m. p.m. 1921. I certify that (I) (this hospital) attended the deceased from April 10, 1962, to April 14, 1962, that (I) (we) lastsaw the deceased alive on April 11, 1962, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED
4/16/62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

22e. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

DATE

26. FEE

27. PAYMENT

28. PAYMENT

29. PAYMENT

30. PAYMENT

31. PAYMENT

32. PAYMENT

33. PAYMENT

34. PAYMENT

35. PAYMENT

36. PAYMENT

37. PAYMENT

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283. PAYMENT

284. PAYMENT



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05092

CERTIFICATE OF DEATH

05090

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

MARYLAND

c. LENGTH OF STAY IN 1b

5 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Western Maryland State Hosp.

First

Middle

3. NAME OF

DECEASED
(Type or print)

Josse Franklin Greene

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B.

DATE OF BIRTH

WIDOWED DIVORCED

May 28, 1885

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Hag. Gas Co.

11. BIRTHPLACE (County & State, if foreign country)

W. Va

Martinsburg, Berkly. Sp

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Martin Greene

14. MOTHER'S MAIDEN NAME

Susan Smith

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

317-09-2691A Mrs. Virginia Corsi

401. S. Potowm St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Lobular pneumonia, bil.

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying

cerebro-vascular accident

DUE TO
cause lost.

(b) generalis ateriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I.e. (a) cerebro-vascular accident, old & hemiparesis (b) Hypertensive

(c) cardio-vascular disease

19. WAS AUTOPSY PERFORMED?

YES NO 20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

October 19, 1961, to April 1, 1962 that (I) (we) last saw the deceased alive on April 1, 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Victor L. Ramos

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

April 1, 1962

22c. PHYSICIAN'S
NAME (Type)

Victor L. Ramos, M.D.

22d. ADDRESS

Western Md. State Hospital
Hagerstown, Maryland22b. DATE
SIGNED23a. BURIAL, CREMATION, REMOVAL
(Specify)

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Burial

4/4/62

Rose Hill Cemetery

Hagerstown, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Andrew K. Coffman, Hagerstown, Md.

DATE APR 3 '62

Arthur S. Traue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician, then please remove carbon papers. Page 1 and 2 should be filled in by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

05091

1. PLACE OF DEATH

a. COUNTY

Washington

b. C.TY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

JONATHAN

B.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

X

DIVORCED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

13. FATHER'S NAME

Samuel B. Groner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

SHOCK DUE TO MASSIVE BRAIN DAMAGE
FRACTURED RTBS-FRACTURED LEFT ARM
& LEFT LEG.

INTERVAL BETWEEN
ONSET AND DEATH

24 HOURS

19. WAS AUTOPSY
PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I)

WASHINGTON, D.C.

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 3 1/4 MILE FROM GRANTSVILLE
factory, street, office bldg., etc.)
Hour XX: 4-28 Month 1962 Day 62 At work At work RT. #40, GRANTSVILLE, MD.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

DR. E.W.DITTO, JR.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

May 1, 1962

22c. NAME OF CEMETERY OR CREMATORIAL

National Memorial Park

22d. LOCATION (City, town, or country)

Falls Church, Va.

22e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

22f. FUNERAL DIRECTOR

ADDRESS

Georgetown Funeral Home

4217 9th Street N.W.

DATE 4-29-62

MAY 3 '62

Arthur S. Kraus

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Re-pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05094

CERTIFICATE OF DEATH

05092

1. PLACE OF DEATH

a. COUNTY Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN TB

26 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Anthea

Ruth

4. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

W.DOWED DIVORCED

8. DATE OF BIRTH

June 10, 1917

9. AGE (In years)
Last birthday

44

Months

Days

Hours

M.n

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

assembler

10b. KIND OF BUSINESS OR INDUSTRY

aircraft mfg.

11. BIRTHPLACE (County & State, or foreign country)

Somerset, Penna.

13. FATHER'S NAME

Ira R. Barron

14. MOTHER'S MAIDEN NAME

Anna Baltzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank, dates of service)

no

16. SOCIAL SECURITY NO. 17. INFORMANT

214-09-8783

Address

Wm. L. Hankey, Jr., Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DOUE TO

(b)

DOUE TO

(c)

Chronic pyelonephritis

Cardiac Hypertension

R. L.L. Pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

None

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. none 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1961, to Apr. 14, 1962, that (I) (we) last saw the deceased alive on Apr. 14, 1962, and that death occurred at P.M., from the causes and on the date stated above.

22a. SIGNATURE

Harold R. Tritch, Jr.

None

22b. DATE
SIGNED
4-16-62

22c. PHYSICIAN'S
NAME (Type)

Harold R. Tritch, Jr. MD

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

302 N. Potomac St-Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
burial

23b. DATE THEREOF
4-17-62

23c. NAME OF CEMETERY OR CREMATORIUM
Rest Haven Cemetery

23d. LOCATION (City, town or county)
Hagerstown, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son, Hagerstown, Md.

ADDRESS

25e. REC'D BY REGISTRAR

25f. REGISTRAR'S SIGNATURE

DATE APR 18 '62

Arthur S. Tritch

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DERT.

M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

TO
Burial

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural) Sharpsburg

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sharpsburg On RFD #34

3. NAME OF
DECEASED
(Type or print)

Donald

Alvin

Helman Jr.

First

Middle

Last

4. DATE
OF
DEATH

April

8 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Dec. 8 1942

9. AGE (In years
last birthday)

19 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

Attendant

Filling Station

Mercersburg Pa.

U.S.A.

13. FATHER'S NAME

Donald Alvin Helman Sr.

Anna Virginia Yeager

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

215-42-3778

17. INFORMANT

Mr. J. Edgar Churcley

Sharpsburg RFD #1
Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Fractured Skull

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY

Month, Day, Year

Hour

2:30 p.m.

11-8

19 62

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Struck abutment of underpass R# 34, 2 mile West of Sharpsburg, Md.

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

State R# 34 Sharpsburg, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection , Inquiry , and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

4-9-62

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

Sharpsburg Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country) (State)

Sharpsburg Maryland

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

APR 12 '62

Arthur S. Kraus

requires that the death certificate be ex-
-d by the attending physician and
- move to the funeral

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05094

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASH. CO. HOSPITAL

First

Middle

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

3 WEEKS

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

b. COUNTY

MARYLAND

WASHINGTON

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

d. STREET ADDRESS

22 SOUTH POTOMAC ST.

Last

Month

Day

Year

4. DATE OF DEATH

APRIL 27.

1962

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

ABRAHAM HELSER

ADDIE DALE

Address \$23 SALEM AVE,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes, give rank, date of service)

220-16-3741 MRS. LE ROY HARTRANFT

HAGERSTOWN MD.

INTERVAL BETWEEN
ONSET AND DEATH

3 wks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Germany from bronchitis.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED

Enter nature of injury in Part I or Part II of item 1b

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/13/62 to 3/20/62, that (I) (we) last saw the deceased alive on 3/13/62, and that death occurred at 3/20/62 M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22d. ADDRESS22b. DATE SIGNED
3/13/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

MAY 1, 1962 FAIRVIEW CEMETERY

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

John W. Bost Boonsboro MD. DATE MAY 4 '62 Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05097

05095

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

First

Middle

3. NAME OF
DECEASED
(Type or print)

Linda

Sue

Hemphill

4. SEX

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Hagerstown, Md.

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

George W. Hemphill

14. MOTHER'S MAIDEN NAME

Esther G. Sheasley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or dates of service)

No

None

None

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Caudate Dilatation

756.2 DUE TO

Conditions, if any, which
gave rise to immediate cause{ (b) gave rise to underlying
(a) cause last, etc.

DUE TO

{ (c) marked adhesions

Post surgical correction of Malrotation of intestine

INTERVAL BETWEEN
ONSET AND DEATH

7 days.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1/19/62 to 1/14/62, that (I) (we) last saw the deceased alive on 1/14/62, and that death occurred at 11 AM, from the causes and on the date stated above.

22e. SIGNATURE

Richard A. Young

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS Hagerstown, Md.

22c. PHYSICIAN'S NAME (Type)

22b. DATE
SIGNED
4/16/6223a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial 4/16/62

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

Rest Haven Cemetery

Hagerstown

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Rest Haven Funeral Chapel

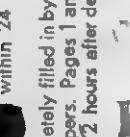
Hagerstown, Md.

25a. REC'D BY REGISTRAR

DATE APR 17 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. ...



1960-1961
1961-1962
1962-1963

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05098

05036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death
by the attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE		Penns		b. COUNTY		Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL Hagerstown		c. LENGTH OF STAY IN 1b 2 1/2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Greencastle		d. STREET ADDRESS		148 N. Carlisle St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Washington B. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
S. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday yrs)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. ADDRESS	16. IF UNDER 24 HRS Min	
Male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 28, 1887	74				Henry Lum	Sarah Atherton	Greencastle, Pa		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Housework		Housekeeping		Washington B. Hospital		USA							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
(If yes, give war or date of service)		None		Kenneth N. Brown		Subarachnoid hemorrhage 18 days							
No						Arteriosclerotic Cardio-vascular disease				15 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY		Month	Day	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
				Hour	o. m.	19			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <u>4/12/62</u> to <u>4/30/62</u> , 1962, that (I) (we) last saw the deceased alive on <u>4/30/62</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE		M.D.		ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE 5/30/62			
		<u>M. J. Brown</u>											
22c. PHYSICIAN'S NAME (Type)		<u>A. C. Breuer, M.D.</u>		22d. ADDRESS		Greencastle, Pa.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town, or county)							
Burial		5-3-1962		Rose Hill Cemetery		Hagerstown							
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<u>Franklin L. Zimmerman, Greencastle, Pa.</u>				MAY 7 '62		<u>Arthur S. Kline</u>							
VR A15 (4) 1SM 9/59													



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05099

CERTIFICATE OF DEATH

05097

1. PLACE OF DEATH

e. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1B

life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEDERED
(Type or print)

First

Middle

Waldo

Emerson

Last

4. DATE
OF
DEATH

Month

Day

Year

April 7, 1962

5. SEX

6. COLOR OR RACE

7. MARRIED

8. DATE OF BIRTH

male

white

WIDOWED

DIVORCED

July 7, 1894

9. AGE (In years) IF UNDER 1 YEAR
last birthday Months Days Hours Min.

67 yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

car inspector

10b. KIND OF BUSINESS OR INDUSTRY

railroad

11. BIRTHPLACE County & State, or foreign country

12. CITIZEN OF WHAT COUNTRY

Hagerstown, Md.

13. FATHER'S NAME

David E. Hill

Ida F. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or dates of service)

yes

WW I

Address

Mrs. Beulah M. Hill, Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Instant

b) Due to

Conditions, if any, which
gave rise to immediate cause

(b) Hypertensive Cardio Vascular Disease

15 months.

(a), stating the underlying
cause last.

c) Due to

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I (a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m.

19

While at work

Not While

at work at work 21 I certify that (I) (this hospital) attended the deceased from 3-1-1962 to 4-7-1962, 19.62 that (I) (we) last
saw the deceased alive on 4-7-1962, and that death occurred at 6:30 P.M. from the causes and on the date stated above

22a. SIGNATURE

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

4-9-62

22c. PHYSICIAN'S
NAME (Type)

Dr. E. W. Ditto, Jr.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial

23b. DATE THEREOF

Apr. 10, 62

23c. NAME OF CEMETERY OR CREMATORI

Rest Haven Cemetery

23d. LOCATION (City, town or county)

(State)

215 W. Washington St., Hagerstown, Md.

Hagerstown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son, Hagerstown, Md.

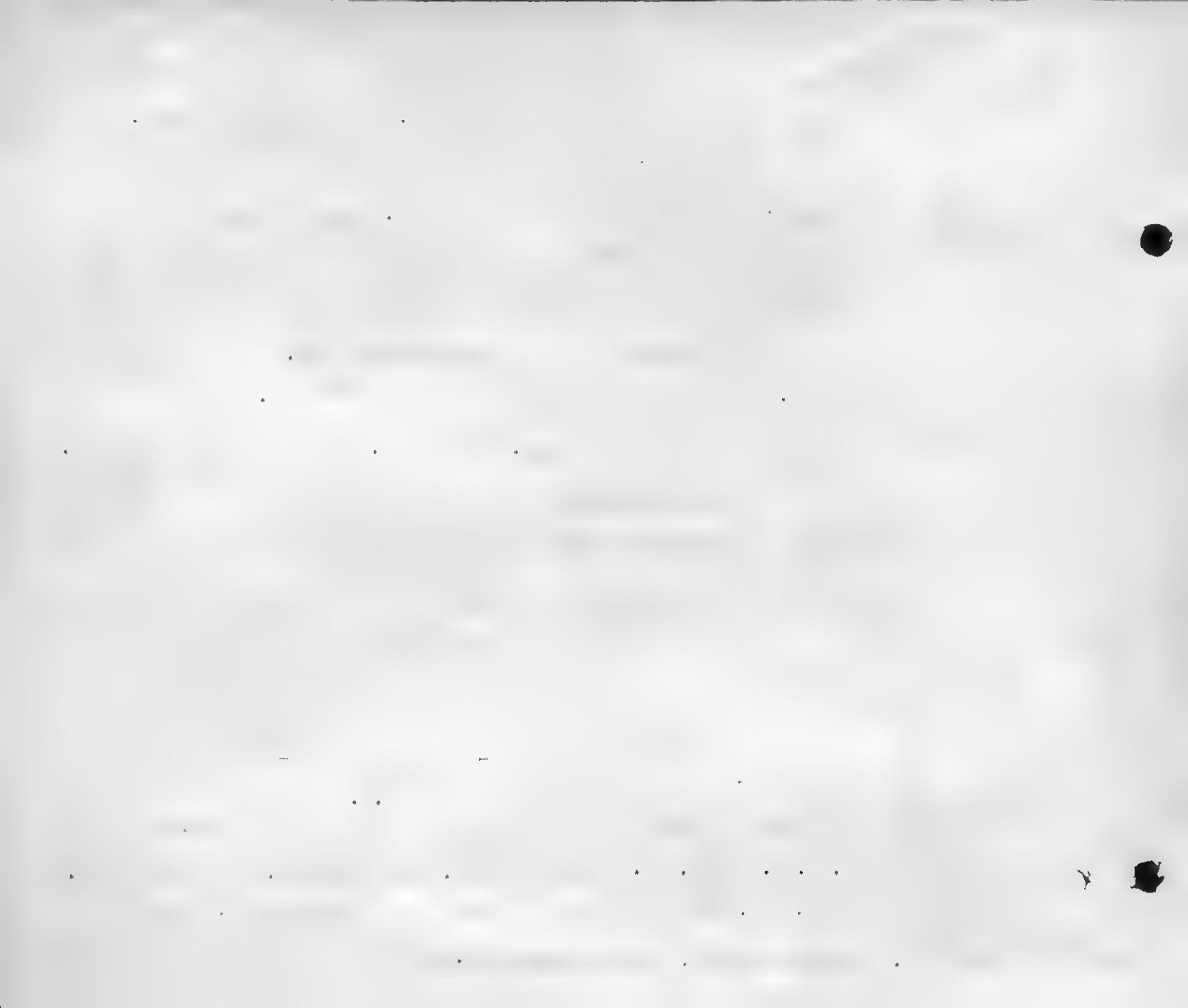
ADDRESS

25a. REC'D BY REGISTRAR

APR 11 '62

25b. REGISTRAR'S SIGNATURE

C. Minnich & Son



1
FOR STATE
HEALTH DEPT.

M

1
please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DAP-3. Page 5 may be retained for your files.
NO FUNERAL DIRECTOR Page 3 should be used as a burial-permit file pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05098

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BOONS BORO

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ENROUTE TO HOSPITAL

First JESSIE Middle

Item #3, film #312, 11/62 sub
2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

MARYLAND

a. COUNTY

WASHINGTON

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

RURAL - EAGLES MILL

e. IS RESIDENCE
ON A FARM?
YES NO

KEEDYSVILLE MD. R.I.

4. DATE OF DEATH APRIL - 6 - 1962

3. NAME OF DECEASED
(Type or print)

LEATHER CLAY HOLMES

Last

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

NELSON

14. MOTHER'S MAIDEN NAME

SUSAN SMITH

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank and dates of service)

NO

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Crushed Chest

17. DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause

(c), stealing the underlying
cause last.

DUE TO

(c)

18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN
ONSET AND DEATH

Few minutes

19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS

PRIMARY or CONTRIBUTING

CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Car he was driving ran into rear of car he was following.

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

8 4-6 1962

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

While at work Not While at work

20f. (City or town) (County) (State)

B# 40 A.

Boonsboro, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-7-62

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

22e. NAME OF CEMETERY OR CREMATORIAL

22f. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22b. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or country) (State)

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22e. ADDRESS

22f. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

VS. A15ME

5M 7/59

22g. ADDRESS

22h. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22i. ADDRESS

22j. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22k. ADDRESS

22l. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22m. ADDRESS

22n. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22o. ADDRESS

22p. DATE THEREOF

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22q. ADDRESS

22r. DATE THEREOF

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24d. REG STRR'S SIGNATURE

22s. ADDRESS

22t. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22u. ADDRESS

22v. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22w. ADDRESS

22x. DATE THEREOF

24e. REC'D BY REGISTRAR

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22y. ADDRESS

22z. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22aa. ADDRESS

22bb. DATE THEREOF

24e. REC'D BY REGISTRAR

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24e. REC'D BY REGISTRAR

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24d. REG STRR'S SIGNATURE

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24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

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22jj. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22kk. ADDRESS

22ll. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

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24e. REC'D BY REGISTRAR

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22oo. ADDRESS

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24e. REC'D BY REGISTRAR

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22rr. DATE THEREOF

24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22ss. ADDRESS

22tt. DATE THEREOF

24e. REC'D BY REGISTRAR

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24e. REC'D BY REGISTRAR

24d. REG STRR'S SIGNATURE

22uu. ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05101

CERTIFICATE OF DEATH

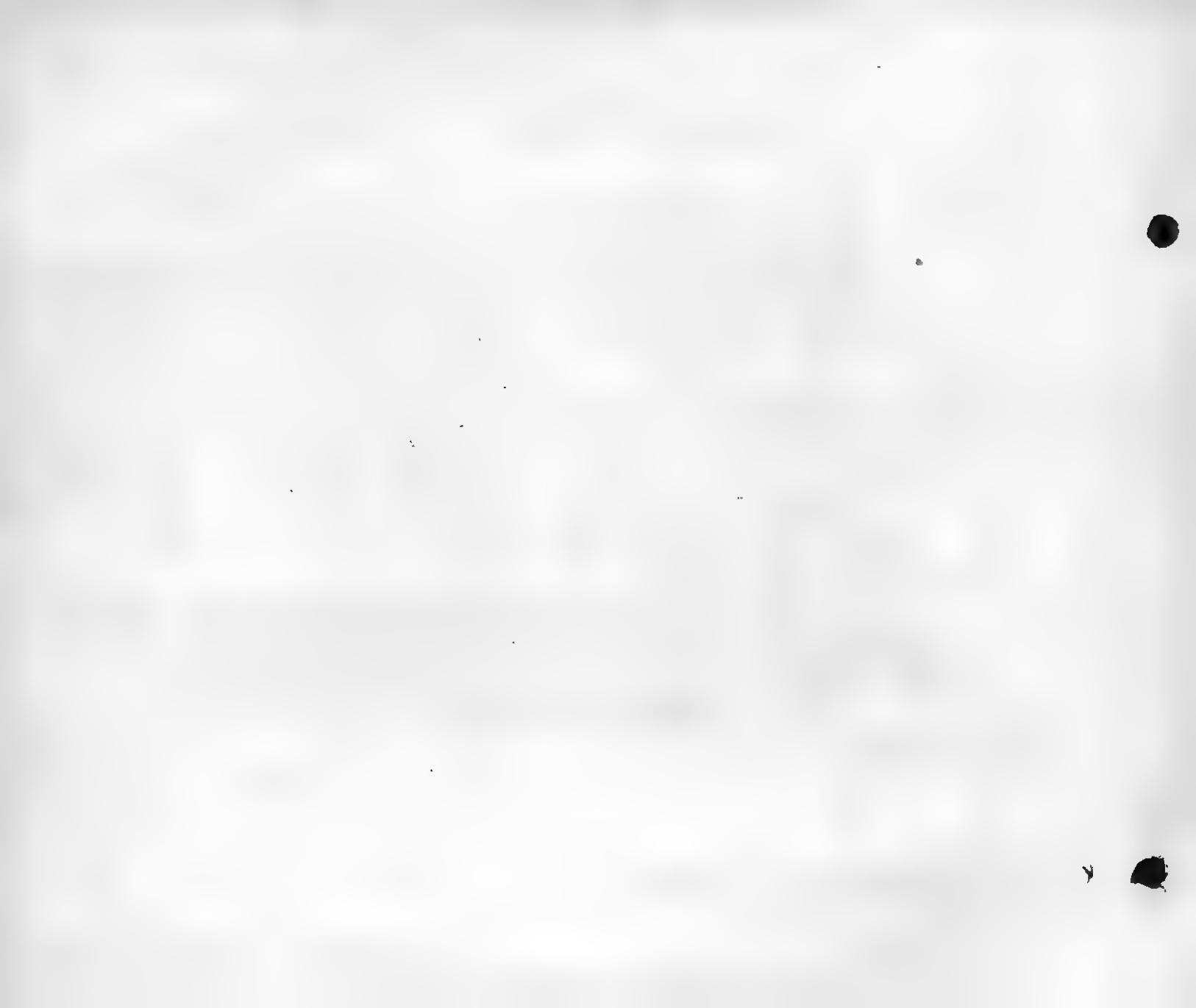
Reg. Dist. No. 05099

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Wash.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pa.		b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Greencastle		d. STREET ADDRESS RD 1 - Greencastle, Pa.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS RD 1 - Greencastle, Pa.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MICHAEL		First	Middle L.	Last	4. DATE OF DEATH 4/25	Month	Day Year 1962
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH 9/26/1884	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance		10b. KIND OF BUSINESS OR INDUSTRY Handis Tool Co.		11. BIRTHPLACE (State or foreign country) Opton, Pa		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Abraham Horsh		14. MOTHER'S MAIDEN NAME Mary E. Sheeley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 204-03-5622		17. INFORMANT Estelle C. Horsh		Address RD 1 Greencastle, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1959</u> , to <u>Apr. 25</u> , 1962, that I last saw the deceased alive on <u>Apr. 25</u> , 1962, and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. Horsh</u>				ADDRESS (Street, city or town, state) Greencastle, Pa. DATE SIGNED 4/25/62			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 4/28/62		22c. NAME OF CEMETERY OR CREMATORIAL Upton Brothers Cemetery, Upton, Pa.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Munch - Greencastle, Pa.		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 30 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05102

CERTIFICATE OF DEATH

05100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached or used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

WILLIAM

HENRY

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lineman - Retired

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY

C&P Tel. Co

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

13 Hagerstown

d. STREET ADDRESS

1707 Sherman Ave

Last

4. DATE OF DEATH

Month

Day

Year

April 6 1962

19

8. DATE OF BIRTH

March 16 1883

9. AGE (In years last birthday)

79

yr.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. BIRTHPLACE (County & State or foreign country)

W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Noah Huff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

--

16. SOCIAL SECURITY NO.

812-05-0839

17. INFORMANT

Mrs Ola D. Huff 1707 Sherman Ave

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Says. | DUE TO
(b). |
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(c). |
euplyme.DUE TO
(d). |
cerebralDUE TO
(e). |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05103

CERTIFICATE OF DEATH

Reg. Dist. No. 05101

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE	
Washington, D.C. MARYLAND		Pennsylvania Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mercersburg, Pa.	
c. LENGTH OF STAY IN lb 4 years		d. STREET ADDRESS R.D. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)		First	Middle
William H. Hunsberger		Lost	4. DATE OF DEATH APR 13, 1962
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY Religion	
11. BIRTHPLACE (State or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAVID HUNSBERGER		14. MOTHER'S MARRIED NAME JANE RINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C.W. HUNSBERGER, MERCERSBURG, PA., R. 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Dis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 17, 1962</u> to <u>APR 13, 1962</u> that I last saw the deceased alive on <u>APR 10, 1962</u> , and that death occurred on <u>APR 13, 1962</u> at <u>1:30 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 4/13/62	
ACTUAL SIGNATURE David R. Brewer M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 4/15/62	
22b. DATE THEREOF 4/15/62		22c. NAME OF CEMETERY OR CREMATORIUM BROADFORING Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE T. H. Ringer, Mercersburg, Pa.		22d. LOCATION (City, town, or county) Washington Co., Md. (State)	
ADDRESS		24a. REC'D BY REGISTRAR DATE APR 16 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05104

CERTIFICATE OF DEATH

05102

1. PLACE OF DEATH

a. COUNTY Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

Cora

Lucinda

Hutson

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

Feb. 26 1882

80 yrs.

9. AGE (in years last birthday)

IF UNDER 1 YEAR

Months

Days

Hours

Min.

d. IS RESIDENCE ON A FARM?

YES NO

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY

U.S.A

13. FATHER'S NAME

James Pierce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Mrs. Mae Hebb Sharpsburg Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

44-111

DUE TO

Conditions, if any, which
gave rise to immediate cause
(b), stating the underlying
(c), stating the underlying
cause last

(b)

DUE TO

(c)

Congestive heart failure

Arteriosclerotic cardiac-vascular disease

INTERVAL BETWEEN
ONSET AND DEATH

1 week.

Arteriolar-nephro-sclerosis

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Diabetes mellitus.

1 year.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1b.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19..., to May 1, 1962, that (I) (we) last saw the deceased alive on May 1, 1962, and that death occurred at M, from the causes and on the date stated above

22e. SIGNATURE

Walter H. Shealy

22b. DATE
SIGNED

May 2, 1962.

22c. PHYSICIAN'S NAME (Type)

Walter H. Shealy M. D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

Sharpsburg, Md.

(State)

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

23b. DATE THEREOF

May 3-62

23c. NAME OF CEMETERY OR CREMATORI

Mt. View Cemetery

23d. LOCATION (City, town or county)

Sharpsburg

(State)

Maryland

24. FUNERAL DIRECTOR'S SIGNATURE

Albert L. Leaf

Williamport, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

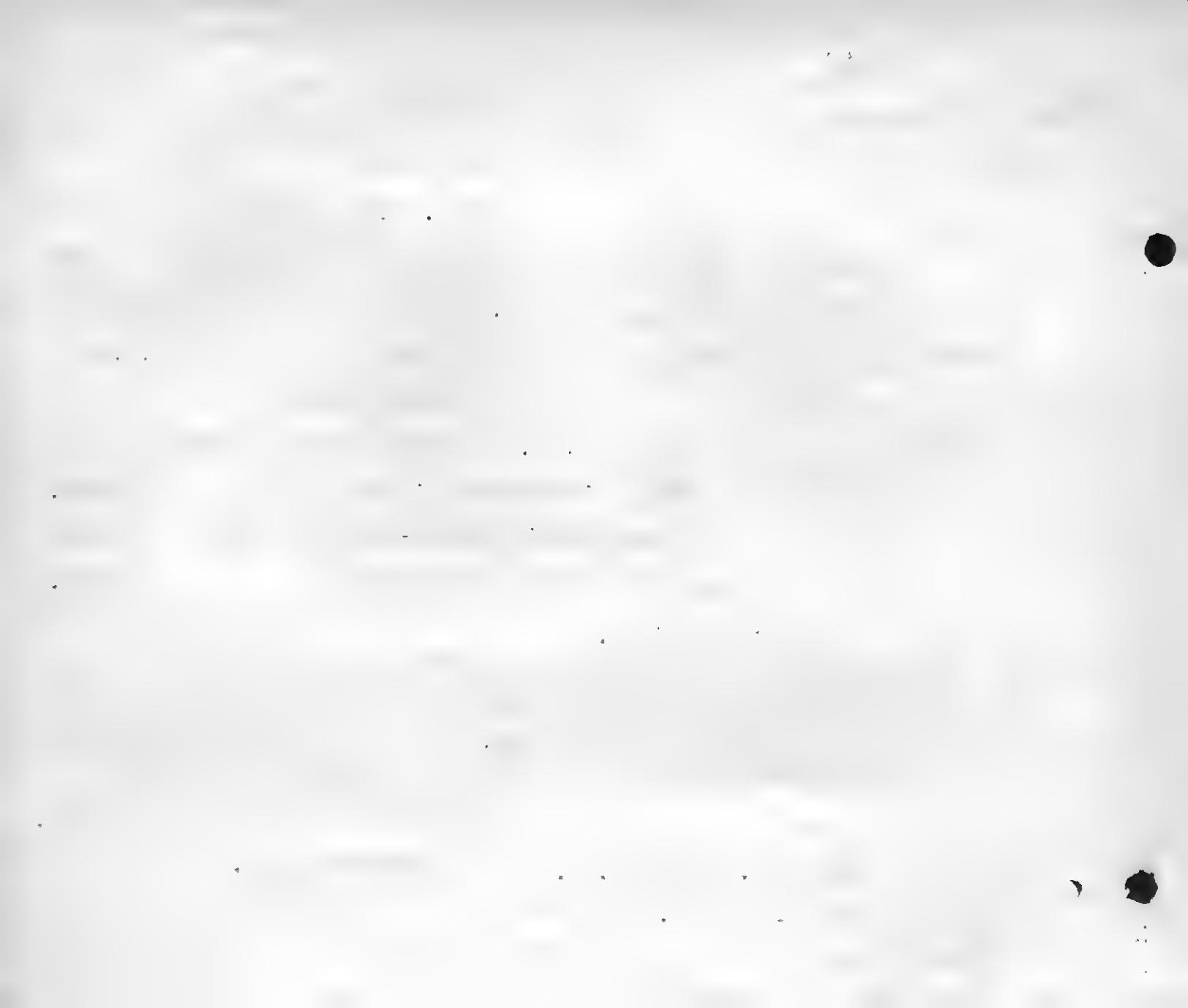
DATE MAY 4 '62

25b. REGISTRAR'S SIGNATURE

Charles S. Kimes

TO ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after

I M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05105

CERTIFICATE OF DEATH

05103

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

9 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

121 East Franklin Street

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

MARY DELOSIER JACKSON

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

February 10, 1882.

80.

9. AGE (in years
last birthday) IF UNDER 1 YEAR

Months

Dey

Hours

1 Min.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY

Self-Employed

11. BIRTHPLACE (County & State, or foreign country)

Hagerstown, Maryland.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

James K. Delosier

14. MOTHER'S MAIDEN NAME

Lydia Clevidence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war and date of service)

No

Z1534-389 Mrs. Bertha M. Bergum,

Hagerstown, Maryland, 124 Randolph Ave.

INTERVAL BETWEEN
ONSET AND DEATH

10 yrs

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hypertension and a fracture of the heart disease

Conditions, if any, which
gave rise to immediate cause(a), stating the underlying
cause last.

Hypertension and a fracture of the heart disease

10 yrs

Other or nothing

10 yrs

DUE TO

(b)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

20d. INJURY OCCURRED

p.m.

While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Jan 11 to April 17, 1962, that (I) (we) last
saw the deceased alive on April 10, 1962, and that death occurred at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22d. ADDRESS22b. DATE
SIGNED

4/12/62

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial 4/19/62

24 FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Colfman, Hagerstown, Maryland.

23c. NAME OF CEMETERY OR CEMATORIAL

ADDRESS

23d. LOCATION (City, town or county)

(State)

Hagerstown, Maryland.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

4/19/62

Andrew K. Colfman



1 M
FOR STATE
HEALTH DEPT.

1 M
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05106 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05104

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clubhouse 3 mi. South Of Sharpsburg

c. LENGTH OF STAY IN lb

State R#34

b. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1. NAME OF
DECEASED
(Type or print)

First

Middle

Ralph

Frederick

Keplinger Sr.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Aug. 4, 1897

9. AGE (In years
last birthday)

64

Yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

e. IS RESIDENCE
ON A FARM?
YES NO

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Owner

10b. KIND OF BUSINESS OR INDUSTRY

Shoe repair shop

11. BIRTHPLACE (State or foreign country)

Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Keplinger

14. MOTHER'S MAIDEN NAME

Anna Mull

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

Yes

W. W. 1

16. SOCIAL SECURITY NO.

214-09-5418

17. INFORMANT

Mrs. Grace Keplinger Hagerstown, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxiation Carbon Monoxide

INTERVAL BETWEEN
ONSET AND DEATH

Recent

911
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Connected hose from exhaust pipe inserted into closed car.

20c. TIME OF INJURY Month, Day, Year
Hour a.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

11 4-30-1962

State R#34 Sharpsburg, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

May 2, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22d. LOCATION (City, town, or country)

(State)

Burial

5-3-62

Rose Hill Cemetery

Hagerstown, Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

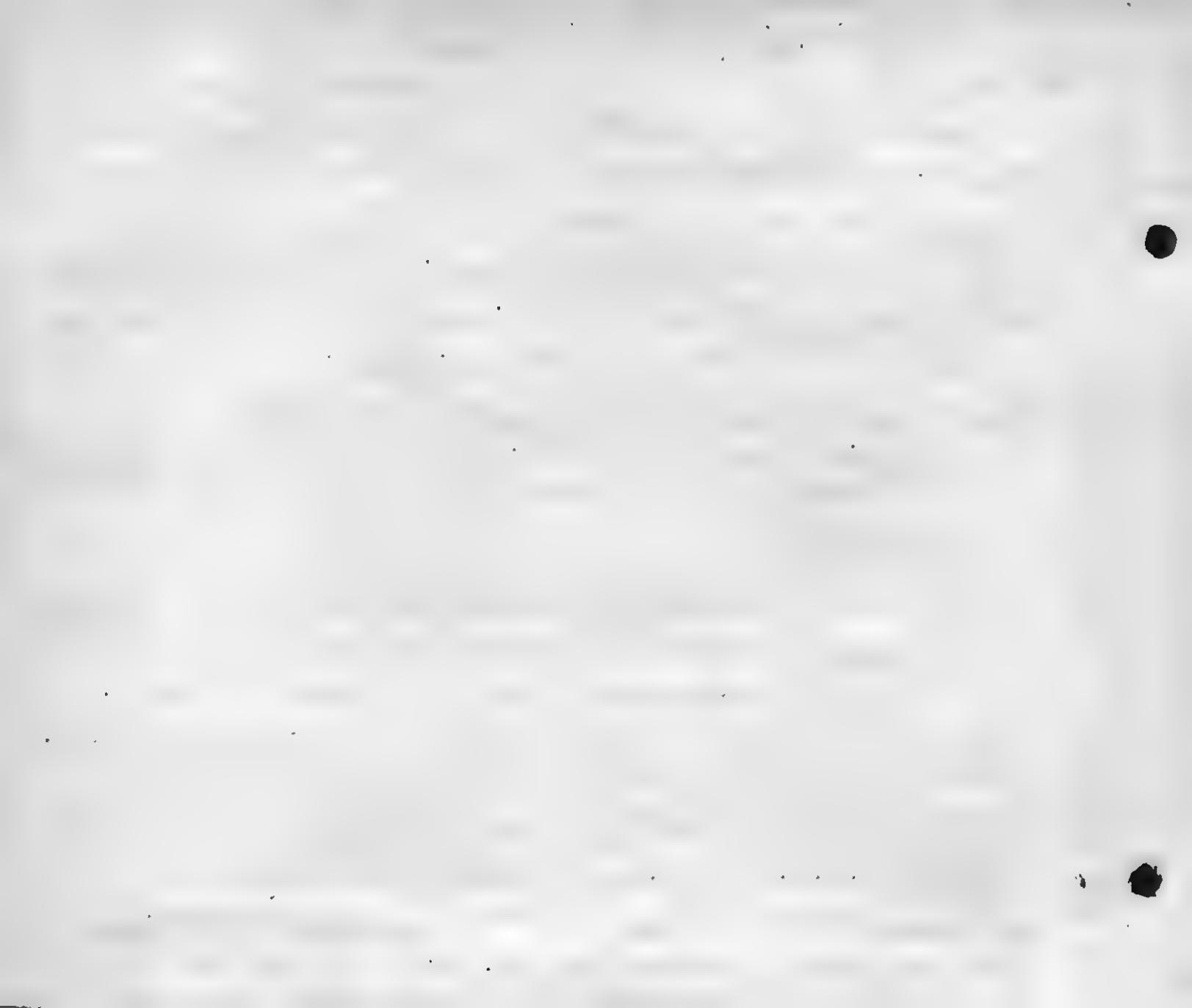
MAY 4 '62

Arthur S. Kraus

Scott F. Minnich & Son Hagerstown, Md.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT 5ME
5M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05107

CERTIFICATE OF DEATH

05105

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

MARYLAND

c. LENGTH OF STAY IN 1b

LFB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASHINGTON COUNTY HOSPITAL

3. NAME OF
DECEASED
(Type or print)

TODD

DWAYNE

KESSELING

4. SEX

6. COLOR OR RACE

M

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

4/12/1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INFANT

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

13. FATHER'S NAME

DONALD LOVELL KESSELING

14. MOTHER'S MAIDEN NAME

ANNY DAVIDSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (Hyphenate or separate service)

NONF

INFORMANT

Address EAGLESTOWN
PA.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)770
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last:
DUE TO
(b)
DUE TO
(c)

Hydrops Fetalis

INTERVAL BETWEEN
ONSET AND DEATH
2 hrs

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY
Hour e.m. none
p.m. 1920d. INJURY OCCURRED
While at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from... Apr. 12, 1962, to Apr. 12, 1962, that (I) (we) last saw the deceased alive on.. Apr. 12, 1962, and that death occurred at 10AM, from the causes and on the date stated above.

22e. SIGNATURE

Harold R. Tritch Jr.

22f. DATE
SIGNED
4-13-6222c. PHYSICIAN'S
NAME (Type)

Harold R. Tritch, Jr. MD

ATTENDING
PHYS.
MED. DIRECTOR
STAFF PHYS. 22d. ADDRESS
302 N. Potomac St Hagerstown, Md.23a. BURIAL, CREMATION
REMOVAL (Specify)

FURNAL

23b. DATE THEREOF
4/13/6223c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS

23d. LOCATION (City, town or county)

(State)

HAGERSTOWN MD.

24. FUNERAL DIRECTOR'S SIGNATURE

W. J. Horment, Hagerstown, Md.

25a. REG'D BY REGISTRAR

DATE APR 19 '62

25b. REGISTRAR'S SIGNATURE

Charles L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

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TO HOSPITAL OR ATTENDING PHYSICIAN:

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TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN:

The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR:

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05108

CERTIFICATE OF DEATH

05106

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN IB

6 months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Western Maryland State Hospital

3. NAME OF DECEASED
(Type or print)

Clara

First

AGNES

5. SEX

Female

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Garrett, Somerset Co. Pa.

13. FATHER'S NAME

Kaiser Kimmel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Toledo, Ohio
Mrs. Mary Vaillant 4055 Walker Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

LOBULAR PNEUMONIA BILATERAL

INTERVAL BETWEEN
ONSET AND DEATH
5-6 DYS.W32
Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

CEREBRAL THROMBOSIS

3 MONTHS

DUE TO

(c)

GENERALIZED ARTERIOSCLEROSIS

UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 19. WAS AN AUTOPSY

ACUTE & CHRONIC PYELONEPHRITIS - DIABETES MELLITUS

PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

p.m.

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

While at work Not While at work

21. I certify that (I) (this hospital) attended the deceased from Aug 16, 1961 to April 4, 1962 that (I) (was) last saw the deceased alive on April 4, 1962, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Antonio U. Pella

22c. PHYSICIAN'S NAME (Type)

NAME (Type)

REMOVAL (Specify)



1
FOR STATE
HEALTH DEPT.

M

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05107

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

MARYLAND

c. LENGTH OF STAY IN 1B

Life

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

Douglas

Lee

Kunkle

4. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

November 4, 1942

11. BIRTHPLACE (State or foreign country)

Hagerstown, Md.

13. FATHER'S NAME

Jack U. Kunkle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mr. J. U. Kunkle 443 N. Prospect St. Hagerstown, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Cerebral Lacerations

DUE TO Gastric Ulcer With Hemorrhage

(c) Pneumonitis

INTERVAL BETWEEN
ONSET AND DEATH

3 months

3 months

Recent

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

In Auto accident on R# 40 A. 5 mi. East of Hagerstown, Md.

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

20f. (City or town)

(County)

(State)

While Not While

factory, street, office bldg., etc.)

at work at work

Route 40 A.

Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

A. E. Ditto

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

Dr. E. H. Ditto, Jr.

DEPUTY MEDICAL EXAMINER

4-3-62

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/5/62

22c. NAME OF CEMETERY OR CREMATORIUM

Rest Haven Cemetery

22d. LOCATION (City, town, or country)

Hagerstown

(State)

23. FUNERAL DIRECTOR

Rest Haven Funeral Chapel

ADDRESS

Hagerstown, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

APR 5 '62

C. E. Knott

VS. AT 5ME
5M 9/60



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05110

CERTIFICATE OF DEATH

05108

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

214 NORTH POTOMAC ST.
First Middle

**3. NAME OF DECEASED
(Type or print)**

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

**9. AGE (in years
last birthday)**

**10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**

SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY

U.S. SENATOR

11. BIRTHPLACE (County & State, or foreign country)

Boonsboro WASH. CO. MD.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT F. LAMAR

14. MOTHER'S MAIDEN NAME

NELLIE EAKLE

Address

214 N. POTOMAC ST.

**INTERVAL BETWEEN
ONSET AND DEATH**

MINUTES

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)**

NO.

16. SOCIAL SECURITY NO.

17. INFORMANT

577-56-9651 MRS. ROSS BOWARD

HAGERSTOWN MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

**Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.**

Myocardial Infarction

ARTERIOSCLEROTIC HEART DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AN AUTOPSY
PERFORMED?**

YES NO

20a. ACCIDENT WAS UNDERLYING

**OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

e.m.

p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

26 March 1942

to 20 April 1942

that (I) (we) last

saw the deceased alive on

20 April 1942

and that death occurred at 5 PM

from the causes and on the date stated above

22a. SIGNATURE

D. J. Anderson

**22b. DATE
SIGNED**

20 April 1942

**22c. PHYSICIAN'S
NAME (Type)**

D. J. Anderson

**23a. BURIAL, CREMATION,
REMOVAL (Specify)**

BURIAL

23b. DATE THEREOF

APRIL 23, 1942

23c. NAME OF CEMETERY OR CEMINATORY

BOONSBORO CEMETERY

ADDRESS

BOONSBORO MD.

23d. LOCATION (City, town or county)

BOONSBORO WASH. CO. MD.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John D. Bait

25a. REC'D BY REGISTRAR

Arthur S. Thorne

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

DATE

APR 25 '42

15M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05111

CERTIFICATE OF DEATH

05109

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1B

MARYLAND

2 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)First
BerthaMiddle
MAYLast
Lare

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

DATE OF BIRTH

16 Dec 1879

4. DATE
OF
DEATHMonth
AprilDay
12Year
196210a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House-work

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles M. Lare

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT

No

(If yes give war and dates of service)

None

Rey E. Lare, Route 1, Knoxville, Md.

Address

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p.m. 19 While at work Not While at work at work19. WAS AUTOPSY
PERFORMED?
YES NO

21. I certify that (I) (this hospital) attended the deceased from Jan 10 1962 to April 12 1962, that (I) (we) last saw the deceased alive on April 11 1962, and that death occurred at 5 A.M. from the causes and on the date stated above

22e. SIGNATURE

G. W. Lare

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
4/12/62

22c. PHYSICIAN'S NAME (Type)

G. W. Lare

22d. ADDRESS

Boonsboro

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial

4-14-62

23c. NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

23d. LOCATION (City, town or county)

Frederick, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Frank R. Smith
M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR

APR 14 1962

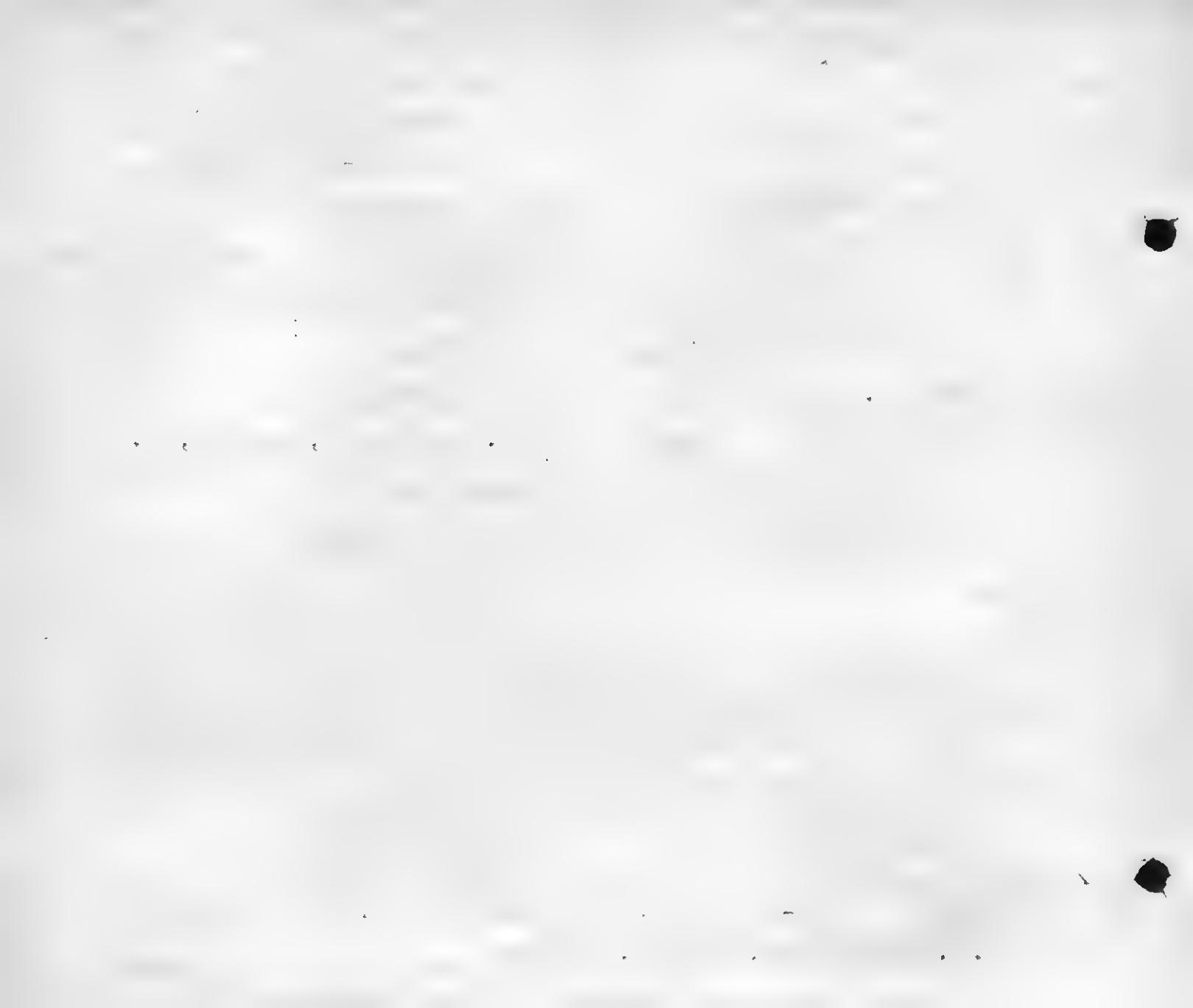
25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
15M 7 61



1
FOR STATE
HEALTH DEPT.
M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05110

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 10. Item 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 62 MADISON AVENUE		d. STREET ADDRESS 62 MADISON AVENUE	
3. NAME OF DECEASED (Type or print) JAMES FINDLAY		4. DATE OF DEATH Last Month Day Year APRIL 15 1962	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 17 1896	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10b. KIND OF BUSINESS OR INDUSTRY COAL COMPANY	
11. BIRTHPLACE (State or foreign country) WASHINGTON MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES A LITTLE		14. MOTHER'S MAIDEN NAME SOPHIA FINDLAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> WW 1		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. NANCY KNOWLES		200 E 66 th STREET NEW YORK CITY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH Recent	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Descending Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diastatic Perforation Of Ascending Colon With DUE TO Acute Generalized Peritonitis. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. E. D. Ditto</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-20-62 DATE SIGNED 215 W WASHINGTON ST HAGERSTOWN MARYLAND	
EXAMINER'S NAME (Type) E. W. DITTO JR. M. D.		Address (Street, city, town, or county) 22d. LOCATION (City, town, or county) (State)	
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22f. DATE THEREOF 4-18-62	
22g. NAME OF CEMETERY OR CREMATORIAL RIVERVIEW CEMETERY		22h. ADDRESS	
23. FUNERAL DIRECTOR <i>Charles S. Krause</i> SOUTHERN ROUZER FUNERAL HOME HAGERSTOWN MARYLAND		24e. REC'D BY REGISTRAR APR 23 '62	
		24f. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05113

CERTIFICATE OF DEATH

05111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FULTON

MARYLAND

c. LENGTH OF STAY IN IB

3 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

GARDEN CITY HOSPITAL

3. NAME OF DECEASED
(Type or print)First: CALLOTT
Middle: PAULINE
Last: JONES

4. SEX

F MATT

6. COLOR OR RACE

African

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

8/7/1894

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

13. FATHER'S NAME

JAMES JONES

14. MOTHER'S MAIDEN NAME

CITY OF BALTIMORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give rank or grade of service)

NO

16. SOCIAL SECURITY NO.

220-22-7980

17. INFORMANT

MRS. CALLOTT JONES

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

Coronary Occlusion

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last

DUE TO

(b)

DUE TO

(c)

general arteriosclerosis and

Arterosclerotic heart disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY

Sensitivity -

PERFORMED?

YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m. p.m.

19

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (the hospital) attended the deceased from

Aug 1, 1958, to Aug 24, 1962, that (I) (we) last saw the deceased alive on Mar 24, 1962, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Edward W. Ditto, M.D.

M.D. ATTENDING PHYS.

MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

4/25/62

22e. PHYSICIAN'S NAME (Type)

Edward W. Ditto, 111, M.D.

22d. ADDRESS

17 W. Washington St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

4/16/62

23b. DATE THEREOF

1958

4/16/62

23c. NAME OF CEMETERY OR CREMATORIAL

LOSI HILLS CEM.

1958

23d. LOCATION (City, town or county)

HAGERSTOWN

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

W. J. Norment

Hagerstown, Md.

ADDRESS

17 W. Washington St., Hagerstown, Md.

1958

25a. REC'D BY REGISTRAR

APR 30 1962

1962

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05114

CERTIFICATE OF DEATH

05112

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the physician or attending physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

2. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Garlock Mem. Home

3. NAME OF DECEASED (Type or print)

First

Middle

IDA CATHERINE DELLINGER-LONG

4. SEX

6. COLOR OR RACE

Female White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Lewis Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

204

DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

Generalized Artherosclerosis

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 1920d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)

20f. (City or town), (County), (State)

21. I certify that (1) (this hospital) attended the deceased from Aug 1960 to Apr 122, 1962, that (2) (we) last saw the deceased alive on April 22, 1962, and that death occurred at 2 PM, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Burial 4/25/62 Rest Haven

24. FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE Maryland

b. COUNTY Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. STREET ADDRESS

2112 Virginia Ave

4. DATE OF DEATH April 22 1962 19

9. AGE (in years last birthday) 84 yrs. 5. IF UNDER 1 YEAR Months Days Hours Min

10. BIRTHPLACE (County & State, or foreign country) 11. COUNTRY

Downsville Wash Co Md.

12. CITIZEN OF WHAT COUNTRY USA

14. MOTHER'S MAIDEN NAME

Sarah Forthman

Address

Mrs Bertha Dellinger Williamsport Md

R # 1

INTERVAL BETWEEN ONSET AND DEATH

1 yr

MEDICAL CERTIFICATION

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. ADDRESS

Williamsport Md

22b. DATE
4-24-62
SIGNED

23d. LOCATION (City, town or county)

Hagerstown Wash Co Md (State)

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE APR 26 '62

Cuthbert S. Thomas

15M 7 61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05115

CERTIFICATE OF DEATH

05113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 40 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 116 MANSI RD.	
3. NAME OF DECEASED (Type or print) BIRTHA LOUISE MANN		4. DATE OF DEATH APRIL 25 1962	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
13. FATHER'S NAME JOHN BREWER		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <input checked="" type="checkbox"/> NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. CARL M. MANN		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1532 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Carcinomatous of abdomen Concurrent & desquam. colitis	
20a. ACCIDENT WAS UNDERLYING (1) OR CONTRIBUTING (2) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 April 1962, to 25 April 1962, that (I) (we) last saw the deceased alive on 25 April 1962, and that death occurred at 5 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 4/27/62	
22e. SIGNATURE Eden S. Hoaden		22b. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Eden S. Hoaden		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/62	
23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.		23d. LOCATION (City, town or county) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown, Md.		25a. REC'D BY REGISTRAR APR 30 '62	
ADDRESS		25b. REGISTRAR'S SIGNATURE Clifford S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

91

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05116

CERTIFICATE OF DEATH

05114

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WESTERN MARYLAND STATE HOSPITAL

**3. NAME OF DECEASED
(Type or print)**

First MIDDLE Last
LOTTIE MANZELL MARKELL

5. SEX

FEMALE

6 COLOR OR RACE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOME MAKER

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

DECEMBER 29 1879

82 yrs.

13. FATHER'S NAME

WILLIAM BOWERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

IDA McCALL

Address

WILLIAM C MARKELL HAGERSTOWN MARYLAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

LOBULAR PNEUMONIA

Conditions, if any, which

gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

CARCINOMA OF BLADDER

INTERVAL BETWEEN
ONSET AND DEATH

4 DAYS

28 months.

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? (Yes No)

ARTERIOSCLEROTIC HEART DISEASE. DIABETES MELLITUS

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
p.m. 19 While at work Not While at work

20f. (City or town)

(County)

(State)

21. I certify that (I) (This hospital) attended the deceased from 2-15, 1962 to 4-7, 1962, that (I) (we) last saw the deceased alive on 4-7, 1962, and that death occurred at 11:55, from the causes and on the date stated above.

22a. SIGNATURE

Antonio U. Palla-Rosi

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

ANTONIO U. PALLA-ROSI

22d. ADDRESS

1500 Pa Ave Hagerstown

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

4-11-62

23c. NAME OF CEMETERY OR CREMATORIUM

ROSE HILL CEMETERY

23d. LOCATION (City, town or county)

(State)

HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

SUTER ROUZER FUNERAL HOME HAGERSTOWN MARYLAND

25a. REC'D BY REGISTRAR

APR 10 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05117

CERTIFICATE OF DEATH

05115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are not available, the physician should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

D.R. L. R. M.
 X

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
WASHINGTON		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
MT. LENA - RURAL		14 YEARS	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
BOONSBORO MD. R. 2		MT. LENA - RURAL	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
CLARENCE EDGAR MARTIN		APRIL 16, 1962	
5. SEX		5. COLOR OR RACE	
MALE		WHITE	
6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday) IF UNDER 1 YEAR	
MAY 21, 1896		65 yrs. 10 months 25 days IF UNDER 24 HRS.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY	
RETIRED FARMER		OWN FARM	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
REID WASH. CO. MD. 4-S-19		HARRY J. MARTIN	
14. MOTHER'S MAIDEN NAME		ANNIE CARPENTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.	
YES I W. W. ONE		17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO Conditions, if any, which gave rise to immediate cause (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(e)	
DUE TO (c)		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour e.m. 20d. INJURY OCCURRED p.m. 19 While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3, 1962, to April 16, 1962, that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred at P.M. from the causes and on the date stated above.		22b. DATE SIGNED 4/16/62	
22c. SIGNATURE G. W. Van		22d. ADDRESS Boonsboro, MD	
22e. PHYSICIAN'S NAME (Type) G. W. Van		22f. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Boonsboro Cemetery Boonsboro WASH. CO. MD.	
23b. DATE THEREOF APRIL 19, 1962		23d. LOCATION (City, town or county) (State) Boonsboro, MD	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Bas		25e. RECEIVED BY REGISTRAR APR 23 '62	
ADDRESS Boonsboro MD		25b. REGISTRAR'S SIGNATURE John A. Bas	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. AT SME
SM 2/57

FOR STATE
HEALTH DEPT.

M

Dr. Ditto

05119

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05117

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
WASHINGTON				a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY WASHINGTON	
HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RE-IDENTIFIED ON A FARA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
151 WEST WASHINGTON ST.		151 WEST WASHINGTON ST.		e. IS RE-IDENTIFIED ON A FARA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle EDWARD	4. DATE OF DEATH APRIL - 22, 1962		Month Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCTOBER - 10 - 1923	9. AGE (In years last birthday) 38 yrs	IF UNDER 1YEAR Months Days Hours Min.
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MECHANIC		FARM IMPLEMENT CO.		WASH. CO. MD.	
13. FATHER'S NAME FRED N. MORRISON		14. MOTHER'S MAIDEN NAME EDNA R. JOHNSON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES W.W. 2.		16. SOCIAL SECURITY NO. 215-20-8942		17. INFORMANT FRED N. MORRISON MIDDLEBORG MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (By Smoke)		Few minutes.			
DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
9100 (b) 2nd. And 3rd. Degree Burns Involving Entire Body.					
DUE TO: (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found on bed, mattress completely burned.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 77 4-22- 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				(City or town) Hagerstown, Washington, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>N. E. W. Ditto</i>		DATE SIGNED April 24, 1962			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 25, 1962		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Boonsboro Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Bast</i>		22d. LOCATION (City, town, or county) (State) Boonsboro WASH. CO. MD. (City, town, or county) (State)			
		24a. REC'D BY REGISTRAR APR 27 '62			
		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Price</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05120

CERTIFICATE OF DEATH

05118

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

5 weeks

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wash County Hospital

3. NAME OF DECEASED
(Type or print)

WILLIAM

HAMILTON

MORROW

First

Middle

Last

4. DATE OF DEATH

April 10 1962 19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

1894

Dec 10 1894

67 88 yrs.

9. AGE (in years last birthday)

Months Days Hours M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

Retired

10. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

Ruthvan W. Morrow

Lillie M. Muse

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.

17. INFORMANT

Yes

17. INFORMANT

18. CAUSE OF DEATH (Check only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Agranulocytic Leukemia

20. DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to April 10, 1962 that (I) (we) last saw the deceased alive on April 10, 1962, and that death occurred at 6:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Dr. E.W. Ditto, Jr.

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. DATE SIGNED

22d. ADDRESS

April 11, 1962

215 W. Washington St., Hagerstown, Md.

V.A. (State)

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

4/12/62

23b. DATE THEREOF

Elmwood Cemetery

23d. LOCATION (City, town or county) V.A. (State)

Shepherdstown Jefferson

24 FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE APR 13 '62

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05119

1
SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
Page 4 may be retained by the hospital or attending physician.
2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <i>West Virginia</i>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		b. COUNTY <i>Berkeley</i>						
c. LENGTH OF STAY IN lb <i>4 yrs - 1 mos.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Martinsburg</i>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Williamsport Sanitarium</i>		d. STREET ADDRESS <i>Route #3</i>						
3. NAME OF DECEASED (Type or print) <i>Lillie</i>		First <i>E.</i>	Middle <i>Myers</i>					
4. DATE OF DEATH <i>April 12 1962</i>		Month <i>April</i>	Day <i>12</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Duties</i>		9. KIND OF BUSINESS OR INDUSTRY <i>Home</i>						
10a. FATHER'S NAME <i>Jacob T McQuirk</i>		10b. BIRTHPLACE (County & State, or foreign country) <i>Berkeley Co., W. Va.</i>						
11. MOTHER'S MAIDEN NAME <i>Ellen Whiting</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>						
13. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		14. SOCIAL SECURITY NO <i>27 1893</i>						
15. INFORMANT <i>J. Howard Myers</i>		16. INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i>						
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420-1</i>		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <i>Myocardial infarction Generalized Atherosclerosis</i>						
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>White</i>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Williamsport</i>	20d. (City or town) <i>Williamsport</i>	(County) <i>W. Va.</i>	(State) <i>Md.</i>
20e. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, notify medical examiner) <i>None</i>		20f. DATE SIGNED <i>4-12-62</i>						
21. I certify that () (this hospital) attended the deceased from <i>March 1961</i> to <i>April 12, 1962</i> that () (we) last saw the deceased alive on <i>April 12, 1962</i> and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>M.E. By-Kit</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>M.E. By-Kit</i>		22d. ADDRESS <i>Williamsport Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4-14-1962</i>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Rosedale Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Martinsburg, West Va.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>H.K. Brown</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Hanna</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>				
90		DATE <i>APR 16 '62</i>		DATE <i>APR 16 '62</i>				

25 18

FOR STATE
HEALTH DERT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-form. File Page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05120

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

c. LENGTH OF STAY IN lb

11 Days

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Co. Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

April 11,

19 62

9 AGE (in years
last birthday)

10 IF UNDER 1 YEAR

11 IF UNDER 24 HRS

Months Days Hours Min.

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

B. DATE OF BIRTH

May 2, 1916

10a. USJAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

Walter D. Peddicord

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

Yes

V.W. 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

(a) Pulmonary Embolization; Left Massive
DUE TO Acute Subdural Hematoma, Right Hemisphere

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Contusions Of Right Cerebral Hemisphere
DUE TO Hemorrhagic Necrosis With Cyst Formation Right

(c) Temporal Lobe.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour 19 62

p.m. 4-1

20d. INJURY OCCURRED While Not While
at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County) (State)

20f. (City or town)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

24b. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

22a. BURIAL, CREMATION, REMOVAL (Specify)

22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

24b. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

VS. AISM
SM 9'60

Andrew K. Coffman Hagerstown, Maryland. DATE APR 19 '62

C. E. Coffman



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05123

CERTIFICATE OF DEATH

Reg. Dist. No. 05121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Wash.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pa.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Gateway Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greencastle, Pa.</i>	
d. STREET ADDRESS <i>241 S. Allison St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mae J. Pentz</i>		First <i>Mae</i>	Middle <i>J.</i>
4. DATE OF DEATH <i>April 15</i>	Month <i>April</i>	Day <i>15</i>	Year <i>1962</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 11, 1874</i>
9. AGE (In years lost birthday) <i>87 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>	11. BIRTHPLACE (State or foreign country) <i>Huntingdon Co, Pa.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas McKelvey</i>	14. MOTHER'S MAIDEN NAME <i>Alice Hicks</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO <i>104</i>	17. INFORMANT <i>Stanley Pentz - Greencastle, Pa.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast.</i>	
DUE TO <i>X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Clear Spring Md</i>
20f. (City or town) <i>Clear Spring Md</i>	(County) <i>Frederick Co</i>	(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>April 12, 1962</i> to <i>April 15, 1962</i> , that I last saw the deceased alive on <i>April 14, 1962</i> , and that death occurred at <i>9 AM</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David R. Brewer</i>	PHYSICIAN'S NAME (Type) <i>David R. Brewer</i>	ADDRESS (Street, city or town, state) <i>Clear Spring Md</i>	DATE SIGNED <i>4/17/62</i>
22a. BURIAL, Cremation, Removal (Specify) <i>B</i>	22b. DATE THEREOF <i>4/18/62</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Greencastle, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. W. Wimnoch - Greencastle, Pa.</i>	ADDRESS <i>A. W. Wimnoch - Greencastle, Pa.</i>	24a. REC'D BY REGISTRAR <i>APR 18 1962</i>	24b. REGISTRAR'S SIGNATURE <i>APR 18 1962</i>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05124

CERTIFICATE OF DEATH

05122

TO: Page 4 may be retained by the hospital or attending physician.
 TO: FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Gateway Nursing Home

3. NAME OF
DECEASED
(Type or print)

Edward Clayton

First

Middle

Last

5. SEX

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Iron works

10b. KIND OF BUSINESS OR INDUSTRY

Metal worker

11. BIRTHPLACE (County & State, or foreign country)

Bendersville Penna.

13. FATHER'S NAME

Charles Elmer Porter

14. MOTHER'S MAIDEN NAME

Catherine Petras

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

217-10-3283A

Mrs. Virginia A. Syncire

Address

Hagerstown, Md.

417 Brewer Ave.

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

217-10-3283A

Mrs. Virginia A. Syncire

417 Brewer Ave.

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Mar 1, 1962 to April 22, 1962, that (I) (we) last saw the deceased alive on April 21, 1962, and that death occurred at 301 W. Preston St., M., from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/25/62

23c. NAME OF CEMETERY OR CREMATORIAL

Rest Haven Cemetery

24d. LOCATION (City, town or county)

Hagerstown,

22b. DATE
SIGNEDATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

24 FUNERAL DIRECTOR'S SIGNATURE

Wm. G. Host

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE APR 26 '62

Charles S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. To FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05125

CERTIFICATE OF DEATH

05123

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

Mary

Cassandra

MARYLAND

c. LENGTH OF STAY IN HOSPITAL

45 years

5. SEX

Female

6. COLOR OR RACE

White

Middle

10e. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

13. FATHER'S NAME

Sidney Ellis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO. J. 17. INFORMANT

214-09-2764 Charles Potterfield Hagerstown, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Subarachnoid hemorrhage

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Rupture of aneurysm of left vertebral
artery

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED? YES NO

None

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour
a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (William T. Layman, M.D.) attended the deceased from Apr. 3 1962 to Apr. 5 1962, that (I) (We) last saw the deceased alive on Apr. 5 1962, and that death occurred at 2:45 p.m. from the causes and on the date stated above.

22e. SIGNATURE

22d. PHYSICIAN'S NAME (Type)

William T. Layman, M.D.

M.D.
ATTENDING
PHYS.

MED.
DIRECTOR STAFF
PHYS.

4-6-62
22b. DATE
SIGNED

5 Public Square
Hagerstown, Maryland

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial 4-8-62

23b. DATE THEREOF

Rose Hill Cemetery

23d. LOCATION (City, town or county)

Hagerstown, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son Hagerstown, Md.

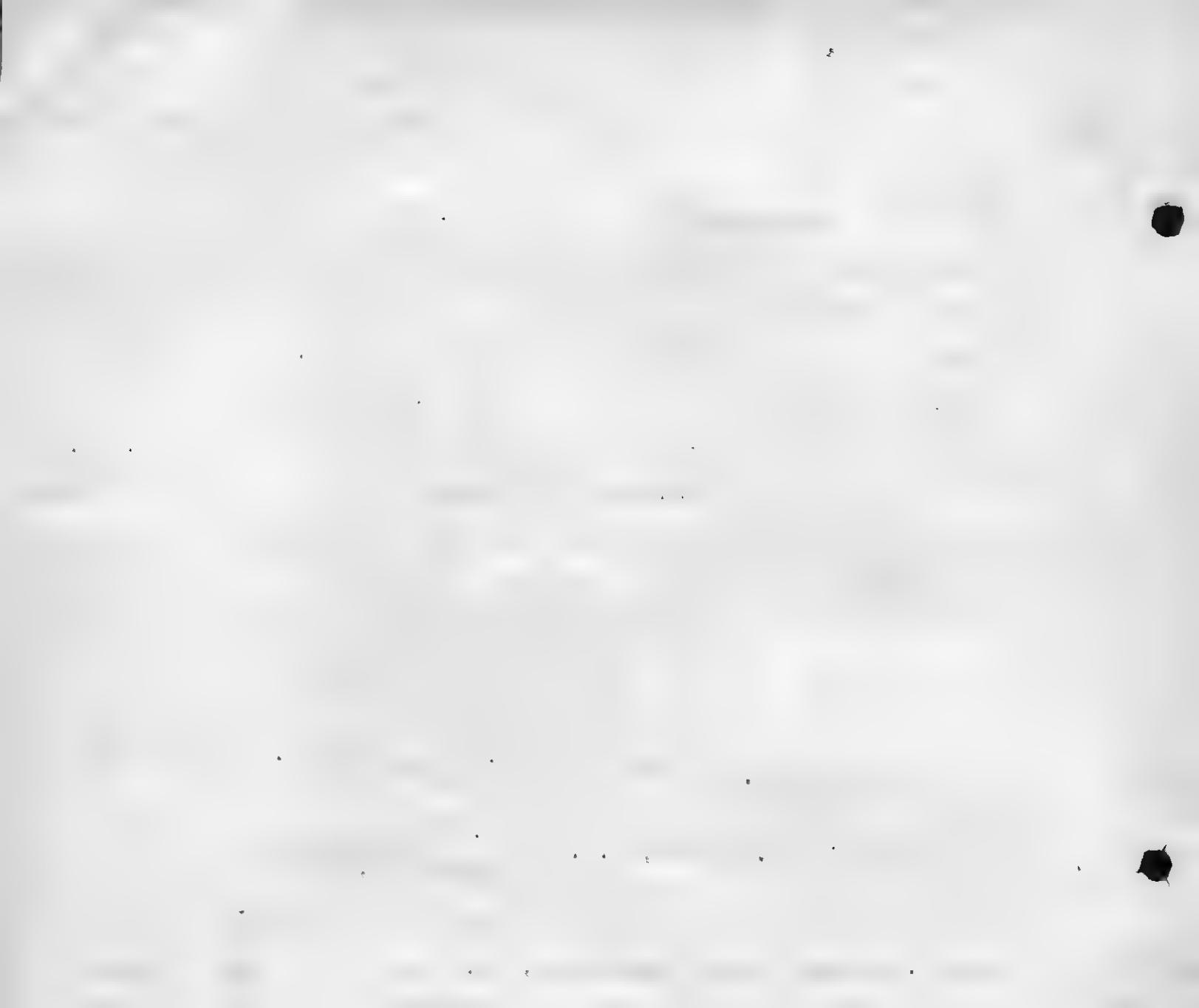
ADDRESS

25e. REC'D BY REGISTRAR

APR 9 1962

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05126

CERTIFICATE OF DEATH

05124

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN TB

6 WEEKS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASHINGTON COUNTY HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

DOROTHY

MARIE

RAIFSNIDER

4. SEX

FEMALE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESCLERK

DEP'T STORE

13. FATHER'S NAME

MILFORD J BOUGHTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

17 x

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(b), stating the underlying
cause last.

DUE TO

(c)

217-10-3270 HARVEY E RAIFSNIDER HAGERSTOWN MARYLAND

INTERVAL BETWEEN
ONSET AND DEATH

10 days

Harmless

Carcinoma Cervix

10 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

Carcinoma Breast

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

none

20c. TIME OF INJURY Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour

a.m.

p.m.

While at work Not While at work

21. I certify that (I) (this hospital) attended the deceased from

REMOVAL (Specify)

16 March 1962 to 30 April 1962

that (I) (we) last

saw the deceased alive on 30 April 1962

and that death occurred at 10 AM

from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE SIGNED

16 March 1962

22c. PHYSICIAN'S NAME (Type)

FRANK E BRUMBACK M. D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS

16 March 1962

22d. ADDRESS

170 W WASHINGTON ST.

HAGERSTOWN MARYLAND

(City, town or county)

(State)

23a. BURIAL, CREMATION, OR REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

BURIAL 5-2-62

REST HAVEN CEMETERY

HAGERSTOWN MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE

MAY 3 1962

Arthur S. Kraus

SUTER-ROUZER FUNERAL HOME HAGERSTOWN MARYLAND



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05127

CERTIFICATE OF DEATH

05125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

M
136 W. WASH.
136 W. WASH.
136 W. WASH.

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

HAGERSTOWN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

WASH. Co. HOSPITAL

3. NAME OF DECEASED
(Type or print)

DANI

DIANE

REED

4. SEX

FEMALE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

NONE

14. MOTHER'S MAIDEN NAME

WASH. Co. MD.

U.S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE) (a)

Acute Respiratory Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO
(b) Bilateral basal pneumonia
(c) Hypoesthesia grise

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 15, 1962, to April 15, 1962, (I) (we) last

saw the deceased alive on April 15, 1962, and that death occurred at 3:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

George Jennings

22b. DATE SIGNED

4/17/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John H. East.

BoONSBORO MD.

25a. REC'D BY REGISTRAR

APR 23 '62

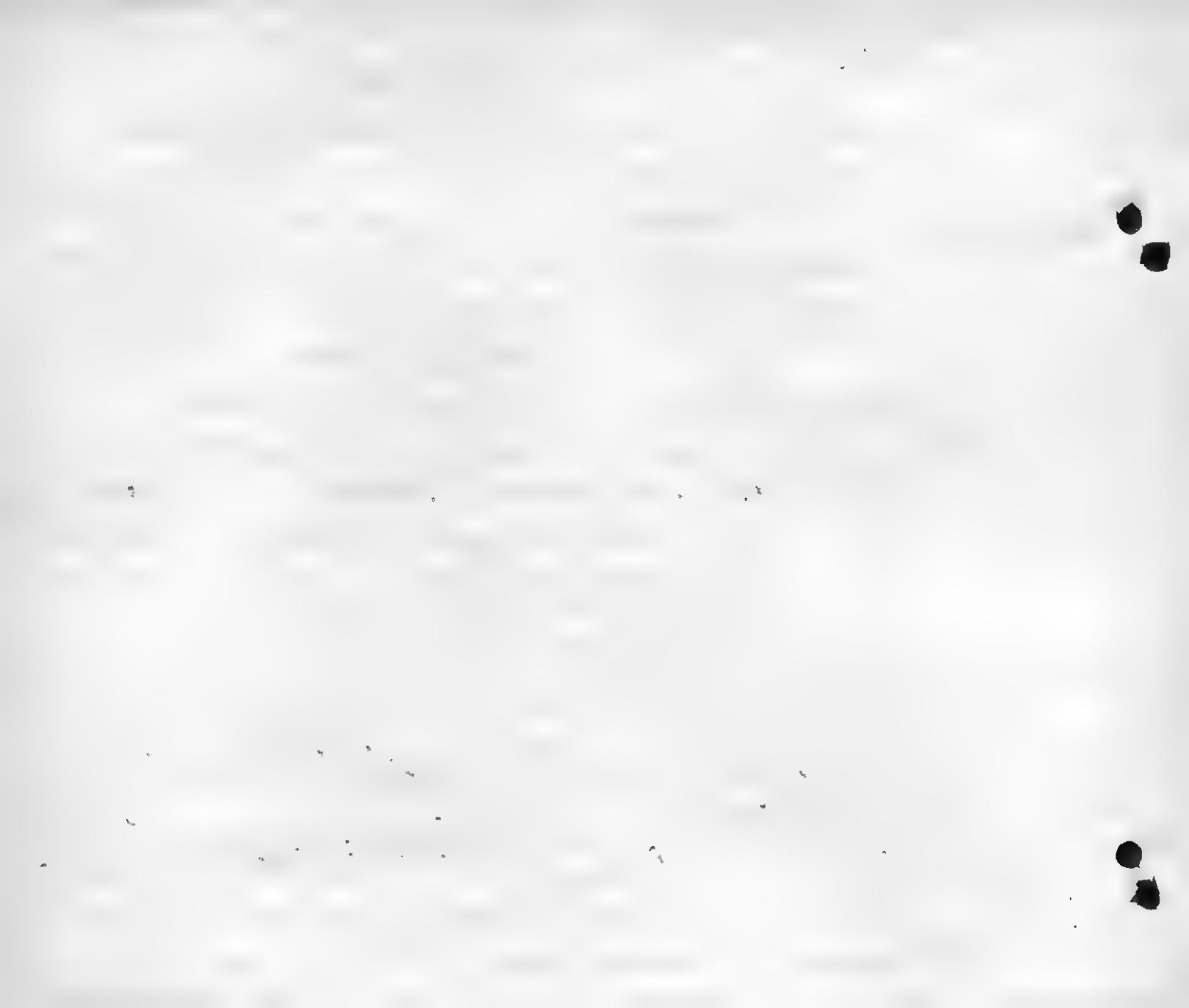
25b. REGISTRAR'S SIGNATURE

John H. East.

BoONSBORO MD.

25c. DATE

4/17/62



FOR STATE
HEALTH DEPT.

M

TO FURNAL DIRECTOR: This certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. It should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05128

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05126

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

10 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington City, Hospital

Middle

3. NAME OF
DECEASED
(Type or print)

Lelia

Caroline

Reigh

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Waitress

10b. KIND OF BUSINESS OR INDUSTRY

10c. BIRTHPLACE (State or foreign country)

11. FATHER'S NAME

James Luther Wine

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) [If yes give rank and dates of service]

No

16. SOCIAL SECURITY NO.

17. INFORMANT

216 20-9879

Anna Lee Gochenour

Address

Donald Reigh, 1369 Marshall St.
Hagerstown, Md.

INTERVAL BETWEEN
ONSET AND DEATH

12 days

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Comminuted Basilar Skull Fracture

DUE TO Compounded Through Cribriform Plate & Ethmoid Sinus

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b) Lepto meningitis Acute

DUE TO

(c) Cerebral Congestion & Edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Passenger in Taxi that collided with a truck.

20c. TIME OF INJURY Month, Day, Year (20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour e.m.

While at work

Not While at work

Street Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

April 16, 1962

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

22f. NAME OF CEMETERY OR CREMATORI

Burial 4/17/62

Rest Haven Cemetery

Hagerstown, Md.

23. FUNERAL DIRECTOR

ADDRESS

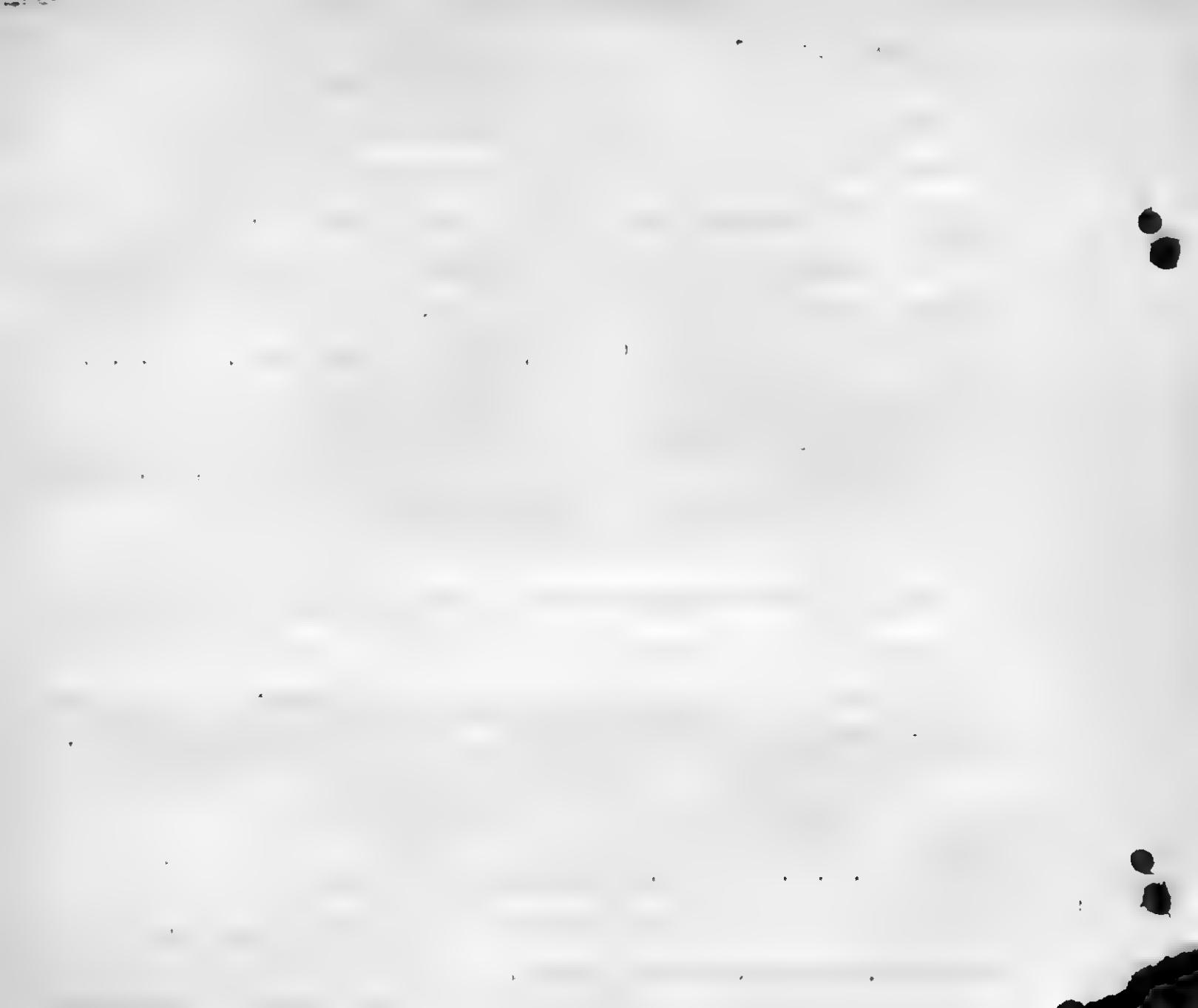
DATE

24b. REG'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

4/18/62

Andrew K. Coffman, Hagerstown, Md.

VS. AISM
5M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are not available, the physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05129

CERTIFICATE OF DEATH

05127

1. PLACE OF DEATH

a. COUNTY

/Hagerstown Washington MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

9 Months

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Western Maryland State Hospital

3. NAME OF DECEASED
(Type or print)

First MIDDLE Last

LAURA ALICE RICHARDS

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

August 3rd 1901

4. DATE OF DEATH

APRIL

6

1962

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (County & State, or foreign country)

Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

John H. Whittaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Pauline L. Poole

Address

Same as # 2. Dau.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

ACUTE CORONARY OCCLUSION

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
FEW MINUTES

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

RHEUMATOID ARTHRITIS

20a. ACCIDENT WAS UNDERLYING

 OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a.m.

p.m.

19

20d. INJURY OCCURRED

White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (This hospital) attended the deceased from 7-18-1961, to 4-6-1962, that (I) (we) last saw the deceased alive on 4-6-1962, and that death occurred at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Antonio U. Vellagran

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

ANTONIO U. PAOLOSKI

22d. ADDRESS

1500 Pa Ave Hagerstown

23a. BURIAL, CREMATION, (Specify)

23b. DATE THEREOF

Burial April 11th 62

23c. NAME OF CEMETERY OR CREMATORIUM

St. Barnabas Cemetery

23d. LOCATION (City, town or county)

Oxon Hill, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Simons Bros.

1661 Good Hope Rd. SE
Washington, DCADDRESS
DATE APR 9 '6225a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE

Arthur S. Hines

VR A15 (4)
15M 7/61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05130

CERTIFICATE OF DEATH

Item 256 Film G 311 4/13/62 ink

05128

1. PLACE OF DEATH

e. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Wovorton

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MARYLAND

c. LENGTH OF STAY IN lb

Life

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (County & State, or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Joshua Ohler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Sarah Grouse

Address

Mrs. Edith Kelbaugh, Knoxville, Ia.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)1422
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lastDUE TO
(b)
DUE TO
(c)

Pulmonary Edema

Myocardial Decompensation

Advanced Cardio Vascular disease 5 yrs

INTERVAL BETWEEN
ONSET AND DEATH
2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Chronic Nephritis

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

OR CONTRIBUTING CAUSE OF DEATH
(If either, notify MEDICAL EXAMINER)

20c. TIME OF INJURY

Month, Day, Year

Hour
a.m.
p.m.

19

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office, bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Jan 4 1962 to April 1962, that (I) (we) last
saw the deceased alive on April 4 1962, and that death occurred at M, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

H. T. PRICE

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED

23a. BURIAL, CREMATION, DATE THEREOF

REMOVAL (Specify)

Burial

4-8-1962

23b. NAME OF CEMETERY OR CEMETORY

St. Luke's Episcopal Cemetery

Brooklyn/Baltimore/North

23d. LOCATION (City, town or county)

(State)

Brownsville, Md

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

B. H. Field Brunswick, Maryland

25a. REC'D BY REGISTRAR

DATE APR 10 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Price



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05132

CERTIFICATE OF DEATH

Reg. Dist. No. 05130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 years in Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle Rosenberry	Last April 16, 1962
4. DATE OF DEATH	Month April	Day 16	Year 1962
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1927
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Central City, Pa.	
11. BIRTHPLACE (State or foreign country) Central City, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles William Deneen		14. MOTHER'S MAIDEN NAME Bertha Mae Kirchner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Bertha Logsdon Hyndman, Pa. RD#1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591		DUE TO Hyster intestinal hemorrhage	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Cerebrum of brain DUE TO Alcoholism	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		(c) Alcoholism	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 April , 19 62 , to 16 April , 19 62 , that I last saw the deceased alive on 15 April , 19 62 , and that death occurred at 1164 M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 115 W. Welsh St	
ACTUAL SIGNATURE Elder A Houchin, M.D.		DATE SIGNED 4/14/62	
PHYSICIAN'S NAME (Type) Elder A Houchin		Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1962	
22c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery		22d. LOCATION (City, town, or county) Hyndman, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Barney J. Engler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR SPR 19 62		24b. REGISTRAR'S SIGNATURE Arthur K.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film 6511 4/25/62 m

05131

1. PLACE OF DEATH
& COUNTY

WASHINGTON

MARYLAND

b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town)

HAGERSTOWN

c. LENGTH OF STAY IN lb

10 YRS.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WASHINGTON COUNTY HOSPITAL

3. NAME OF
DECEASED
(Type or print)

MARY ANN

SAMPSELL

Last

4. DATE
OF
DEATH

APRIL

17 1962

19 62

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

1896

7/17/88

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARVEY MYFFS

14. MOTHER'S MAIDEN NAME

ANNIE WOLF

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No, or Unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MP. REGINALD F. SAMPSELL

Address

HAGERSTOWN
MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)+22 DUE TO
(b)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(c)Cerebral v. Collapse
Cerebral vascular accident
Arteriosclerosis gen.INTERVAL BETWEEN
ONSET AND DEATH

3W

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

May 1962, to. Apr 17 1962 that (I) last

saw the deceased alive on. Apr 16 1962, and that death occurred at.....M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Louis

GRAFF

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

4/17/62

23a. BURIAL, CREMATION, REMOVAL
REMOVAL (Specify)

4/19/62

23b. DATE THEREOF

4/19/62

23c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS

BROADFORDING

23d. LOCATION (City, town or county)

WASHINGTON CO. MD.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

W. J. Norment, Hagerstown, Md.

ADDRESS

BROADFORDING

25a. REC'D. BY REGISTRAR

APR 23 1962

25b. REGISTRAR'S SIGNATURE

W. J. Norment

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs in a hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7,61



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 48 hours are required, the physician or hospital should be retained by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

ST. MARYS TOWN

a. LENGTH OF STAY IN 1B

LIFE

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

710 WASHINGTON ST.

3. NAME OF DECEASED (Type or Print)

First
GEORGE

Middle
JOHN

SCHMIDT

Last

4. DATE OF DEATH

Month
APRIL

Day
15

Year
1962

5. SEX

M

6. COLOR OR RACE

WHITE

7. MARRIED **NEVER MARRIED**

WIDOWED **DIVORCED**

8. DATE OF BIRTH

5/20/1874

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

REFINED ANTIQUE DEALER IN BUSINESS

10b. KIND OF BUSINESS OR INDUSTRY

MARYLAND

11. BIRTHPLACE (County & State, or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GOTTLIEB SCHMIDT

14. MOTHER'S MAIDEN NAME

SUSAN ANN MAISACK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) (If yes, give rank or date of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

C. S. MELVIN JOHNSON

Address
ST. MARYS TOWN

MD.

**INTERVAL BETWEEN
ONSET AND DEATH**

sev. yrs

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)**

450 DUE TO

**Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.**

gen'l arteriosclerosis

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?

YES **NO**

20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)

Hour a.m. 19 p.m.

White at work **Not White at work**

20c. TIME OF INJURY

Month, Day, Year

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

ON 4/5/62, 19 at 11:30 P.M.

and that death occurred at.....M.

from the causes and on the date stated above.

22e. SIGNATURE

Howard N. Weeks, M. D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS

22b. DATE SIGNED
4/6/62

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

136 N. Potomac Street

23a. BURIAL, CREMATION REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

DATE APR 10 1962

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

W. J. Horner, Hagerstown, Md.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05133

1. PLACE OF DEATH
a. COUNTY

WASHINGTON

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

RURAL WEVERTON

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

ROUTE 340 WEVERTON

3. NAME OF
DECEASED
(Type or print)

BILLY

First

MARYLAND

c. LENGTH OF STAY IN lb

4 DAYS

5. SEX

MALE

6. COLOR OR RACE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INSPECTOR

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

SHEPLEY

9. AGE (in years
last birthday)

NOV. 11 1917

10b. KIND OF BUSINESS OR INDUSTRY

STATE ROAD COMM.

11. BIRTHPLACE (State or foreign country)

HAGERSTOWN, MARYLAND

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

WILBUR WELLINGTON SHEPLEY

MAMIE GOUKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

NO

16. SOCIAL SECURITY NO

17. INFORMANT

21710 3017

SHIRLEY M. SHEPLEY

FUNKSTOWN, MARYLAND

101 EAST MAPLE STREET

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Thrombotic Occlusions, Anterior Descending And
DUE TO Right Coronary Arteries

INTERVAL BETWEEN
ONSET AND DEATH

Recent

4/21/62

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Myocardial Infarction, Left Ventricle, Old And
DUE TO Recent

(c) Pulmonary Edema

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE


E.W. DITTO JR. M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

4-20-62

DATE SIGNED

215 W Washington St

HAGERSTOWN MARYLAND

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

BURIAL

APRIL 21 1962 ROSE HILL CEMETERY

HAGERSTOWN

MARYLAND

23. FUNERAL DIRECTOR


Charles W. Suter

24a. REC'D BY REGISTRAR APR 23 '62

REGISTRAR'S SIGNATURE

DATE

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

M

99

TO DE [REDACTED] MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05136

05134

1. PLACE OF DEATH

a. COUNTY

WASHINGTON

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

PARAMOUNT (RURAL)

c. LENGTH OF STAY IN 1b

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

HAGERSTOWN

RD #6

(dead on arrival Hagerstown Hospital)

3. NAME OF
DECEASED
(Type or print)

First

Middle

JOSEPH

SHUCK

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

HARMON L SHUCK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

219-36-3198

14. MOTHER'S MAIDEN NAME

MARY M. BURKETT

Address

51 Mary Shuck

Hagerstown

Md

RD #6

INTERVAL BETWEEN
ONSET AND DEATH

Recent

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Thrombotic Occlusion, Anterior Descending Branch
DUE TO Of Left Coronary Artery, Recent

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b) Coronary Atherosclerosis, Generalized

DUE TO

(c) Diabetes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell down cellar steps at his home.

20c. TIME OF INJURY
Month, Day, Year
Hour

20d. INJURY OCCURRED
While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)
factory, street, office bldg., etc.)

(County)

(State)

12:50 P.M. 4-23 1962

Home Hagerstown RD # 6, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

D. E. Ditto

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 24, 1962

Address (Street, city, town, or county)

22a. BURIAL CREMATION
REMOVAL (Specify)

22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

13
23. FUNERAL DIRECTOR
ADDRESS

April 25/1962 Beautiful View

State Line

Md

VS. ATME
SM 7/59

24a. REC'D BY REGISTRAR
DATE

APR 26 '62

24b. REGISTRAR'S SIGNATURE
CURTIS S. THOMAS





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05138

05136

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown Md.

c. LENGTH OF STAY IN 1b

38 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County hospital

First

Middle

3. NAME OF
DECEASED
(Type or print)

Jack

(no)

Stokes

4. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 24 1900

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Concrete Works

11. BIRTHPLACE (County & State, or foreign country)

Williamston, N.C.

13. FATHER'S NAME

Thomas Stokes

14. MOTHER'S MAIDEN NAME

Winnie Spruill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

579-07-7453 Miss Fannie Stokes Newark, N.J.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443X CARDIO-VASCULAR DISEASE

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

HYPERTENSIVE CARDIO-VASCULAR DISEASE.

DUE TO

(c)

DUE TO

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 6, 1962, to April 17, 1962, that (I) (we) last saw the deceased alive on April 7, 1962, and that death occurred after 5 P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Wm. Noel Fender, M. D.

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
20 April 1962

22d. ADDRESS

218 N. Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

4-23-1962

23c. NAME OF CEMETERY OR CREMATORIAL

Odd Fellows Cemetery

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

John R. Watson Jr. Hagerstown Md

25a. REC'D BY REGISTRAR

APR 23 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

TO FORTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after the death. If the physician or attending physician has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05140

CERTIFICATE OF DEATH

05138

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Williamsport

c. LENGTH OF STAY IN lb

MARYLAND

8 mos. 15 mos.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Williamsport Sanitarium

3. NAME OF
DECEASED
(Type or print)

First

Middle

Nettie

5. SEX

Female white

6. COLOR OR RACE

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

August 10, 1869

92 yrs

Last

Month

Day

Year

April 1 14

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Willow Hill, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William W. Stringer

Stringer

14. MOTHER'S MAIDEN NAME

Elizabeth Miller

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Clyde Warnick 231 W Second St.
Waynesboro, PA.INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

(d)

DUE TO

(e)

DUE TO

(f)

DUE TO

(g)

DUE TO

(h)

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FOR STATE
HEALTH DEPT.

M

TO: CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05139

1. PLACE OF DEATH

a. COUNTY

Washington County

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

MARYLAND

c. LENGTH OF STAY IN 1b

5 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

3. NAME OF
DECEASED
(Type or print)

First
Isaac

Middle
Ray

Last
Watson

4. DATE
OF
DEATH

Month
April

Year
1962

5. SEX

M

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH

2/4/62

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

North Carolina

9. AGE (In years
less birthday)
yrs

10. IF UNDER 1 YEAR
Months
2

IF UNDER 24 HRS
Days
4

Hours
Mn.

13. FATHER'S NAME

Julius H. Watson

14. MOTHER'S MAIDEN NAME

Juanita K. Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

none

Address

Juanita K. Watson

Sleepy Creek

INTERVAL BETWEEN
ONSET AND DEATH

20 hours

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a):

4/4/62 X Acute Interstitial Pneumonia

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or Item 18.)

20c. TIME OF INJURY
Hour a.m. Month, Day, Year
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

4-7-62

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Dr. E. W. Ditto, Jr.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/10/62

22c. NAME OF CEMETERY OR CREMATORIUM

Shriver's Cemetery

22d. LOCATION (City, town, or country)

Morgan County, W. Va. (State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

VS. ATIME
5M 7/59

Howard J. Stone Hanover md

DATE APR 10 '62

Arthur S. Thomas

2176

1. *Chloris* (L.) *virginica* L.
2. *Chloris* (L.) *virginica* L.
3. *Chloris* (L.) *virginica* L.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05143

CERTIFICATE OF DEATH

05141

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If out da corporata limits, write RURAL and give nearest town)

Hagerstown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Co. Hospital

3. NAME OF
DECEASED
(Type or print)

HARRY EARL WEAGLEY SR.

First Middle

Last

4. DATE
OF
DEATH April 24, 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

May 26, 1892

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (County & State, or foreign country)

Rouzersville, Pennsylvania.

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

William Weagley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

217-10-3455

Florence M. Sheaffer, 600½ Guilford Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Uremia

DUE TO

(b) Nonfunctioning kidney, right; stone-horn
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.INTERVAL BETWEEN
ONSET AND DEATH

2-3 days

DUE TO calculus right kidney

(c) Anemia secondary

Infinite

Infinite

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(e)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

e.m.

p.m.

19

White Not White
at work at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20e. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 6, 1962 to April 24, 1962, that (I) (we) last saw the deceased alive on April 24, 1962, and that death occurred at 1 PM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

P. R. Meisley, M.D.

M.D.

ATTENDING
PHYS.MED
DIRECTORSTAFF
PHYS.

4/25/62

DATE
SIGNED

22d. ADDRESS

118 West Washington Street
Hagerstown, Maryland

23d. LOCATION (City, town or county) (State)

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

4/27/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CEMETORY

ADDRESS

Weltys Cemetery

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman

Hagerstown, Maryland

DATE APR 26 '62

Cynthia S. Knott

1
FOR STATE
HEALTH DEPT.

AM

TO DIRECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05144

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05142

1. PLACE OF DEATH

a. COUNTY

Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

MARYLAND

c. LENGTH OF STAY IN TB

22 Yrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

48 McKee Ave

First

Middle

Last

Month

Day

Year

3. NAME OF
DECEASED
(Type or print)

HERMAN

DAVID

WEEKS Sr

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Branch Manager Sealtest Foods

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Daniel Weeks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-09-8556

Mrs Beatrice A. Weeks 48 McKee Ave

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Compound Occipital Skull Fracture

DUE TO Cerebral Contusion, Rt. Frontal And Occipital

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Lobes

DUE TO Subarachnoid Hemorrhage

(c) Aspiration Of Vomitus

INTERVAL BETWEEN
ONSET AND DEATH
Recent

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell backwards down stairsteps at his home.

20c. TIME OF INJURY Month, Day, Year

Hour

20d. INJURY OCCURRED While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

10:30 p.m. 4-28-62 19

Home

Hagerstown, Washington, Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

April 30, 1962

Address (Street, city, town, or county)

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/1/62

22c. NAME OF CEMETERY OR CREMATORIUM

Rest Haven Cemetery

22d. LOCATION (City, town, or country)

Hagerstown Wash Co Md.

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

MAY 2 '62

Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05145

CERTIFICATE OF DEATH

05143

1. PLACE OF DEATH

a. COUNTY Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN lb

4 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Western Maryland State Hospital

3. NAME OF
DECEASED
(Type or print)

Lydia

First

Middle

Elizabeth

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED D.VORCED

Last

8. DATE OF BIRTH

Aug. 6, 1882

14. DATE
OF
DEATH

Month 4

22

Day 19 62

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State or foreign country)

Frederick, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Christian Gerlach

14. MOTHER'S MAIDEN NAME

Unknown

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or dates of service)

no

none

Roy L. Wiles, RFD 2, Smithsburg, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

none

Uremia

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

(c)

Chronic Nephritis

INTERVAL BETWEEN
ONSET AND DEATH

3 Weeks

5 years

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Arterio sclerotic heart disease

19. WAS AUTOPSY
PERFORMED?YES NO

20a. TIME OF INJURY Month, Day, Year

Hour e.m. While at work

p.m. 19 Not While at work

20b. INJURY OCCURRED

at work at work 20c. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20d. (City or town)

(County)

(State)

20e. ACCIDENT WAS UNDERLYING 20f. (City or town)OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

21. I certify that (I) (this hospital) attended the deceased from Oct. 22 1958 to April 22 1962 that (I) last

saw the deceased alive on April 22 1962 and that death occurred at 6:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Young E. Chun M.D.

22b. DATE
SIGNED

April 22 1962

22c. PHYSICIAN'S
NAME (Type)

YOUNG E CHUN 1500 Penna Ave. Hagerstown, Md.

23a. BURIAL, CREMATION, DATE THEREOF

REMOVAL (Specify) 4-24-62

burial

23b. NAME OF CEMETERY OR CEMINATORY

Rest Haven Cemetery

23d. LOCATION (City, town or county)

Hagerstown, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE

Scott F. Minnich & Son, Smithsburg, Md. ADDRESS

25e. REC'D BY REGISTRAR APR 26 '62

Arthur S. Thorne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE
HEALTH DEPT.

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 10 to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05144

1. PLACE OF DEATH a. COUNTY Washington	MARYLAND c. LENGTH OF STAY IN 1b 3 wks.	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital	d. STREET ADDRESS 601 W. Franklin Street	
3. NAME OF DECEASED (Type or print) First: JEFFERIES Middle: ALLEN Last: WILLIAMS	4. DATE OF DEATH April 3, 1962	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH October 31, 1911 50 yrs.	9. AGE (In years if under 1 year, if over 1 year, give months and days) IF UNDER 1 YEAR Months Dey IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft Corp.	11. BIRTHPLACE (State or foreign country) Meridian, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Claude Williams	14. MOTHER'S MAIDEN NAME Ruby Dowdle	Address Hagerstown, Maryland Mrs. Margaret Williams, 601 W. Franklin St.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Margaret Williams	INTERVAL BETWEEN ONSET AND DEATH 15 days
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 911.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Beritonitis following gunshot wounds (b) of abdomen Uremic & pneumonitis 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in abdomen		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3-19 1962 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) Home	(County, State) Hagerstown, Washington, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M.D.
ACTUAL SIGNATURE NAME (Type) J. E. W. J. T. Jr.	DATE SIGNED 4/3/62		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/6/62	22c. NAME OF CEMETERY OR CREMATORIAL Hagerstown Wash. Co. 1a/	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR VS. A15ME SM 9/60 Bo:	ADDRESS Andrew K. Coffman, Hagerstown, Maryland	24a. REC'D BY REGISTRAR APR 9 '62	24b. REGISTRAR'S SIGNATURE Charles S. Evans



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington County Hospital

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown

3. NAME OF DECEASED
(Type or print)

Female

Sadie

Blanche

Wolfe

4. SEX

6. COLOR OR RACE

Female

White

7. MARRIED

 NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

May 7, 1884

9. AGE (in years
last birthday)

77

10. IF UNDER 1 YEAR

Months

Days

Hours

Mins

11. IF UNDER 24 HRS.

Days

Hours

Mins

12. IS RESIDENCE
ON A FARM?YES NO

Day Year

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Bakersville, Wash. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John L. Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary Ellen Sellers

Address

None

Mrs. J. E. Pleasant R# 4 Hagerstown, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(IMMEDIATE CAUSE (a))

24/IX DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Pulmonary edema

Acute congestive heart failure

(c)

Bronchitis asthma

INTERVAL BETWEEN
ONSET AND DEATH

2 hrs.

5-6 hrs

years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

HYPERTENSIVE CARDIO-VASCULAR DISEASE

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?YES NO 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last
saw the deceased alive on.... 4/21/1962, and that death occurred at 2:45 AM, from the causes and on the date stated above.

22a. SIGNATURE

John Fender

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
4/2/6222c. PHYSICIAN'S
NAME (Type)

Wm. Noel Fender, M. D.

22d. ADDRESS

218 Potomac St., Hagerstown, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

4/4/62

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

Funkstown Cemetery

23d. LOCATION (City, town or county)

Funkstown Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Rest Haven Funeral Chapel Hagerstown, Md.

Allen G. Hoss

25a. REC'D BY REGISTRAR

APR 5 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

B. A. S. 4
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05148

CERTIFICATE OF DEATH

05146

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. ^{After 4} may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hagerstown

c. LENGTH OF STAY IN 1b

5 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wash County Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH April 14 1962 19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

May 21 1895

9. AGE (in years
last birthday)

66 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Manager

10b. KIND OF BUSINESS OR INDUSTRY

Own Properties

11. BIRTHPLACE (County & State, or foreign country)

Funkstown Wash Co Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph A. Young Sr.

14. MOTHER'S MAIDEN NAME

Mary Bostetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and date of service)

Yes

W.W. # 1

219-36-4624 John B. Young 1141 Hamilton Blvd

Hagerstown Md

INTERVAL BETWEEN
ONSET AND DEATH

4 days

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Myocardial Infarction

Coronary Thrombosis

4 days

4 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While at work Not While at work
p.m. 19 20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from April 10, 1962 to April 14, 1962 that (I) (we) last saw the deceased alive on April 14, 1962, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Lloyd A. Hoffman M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
4/16/62

22c. PHYSICIAN'S NAME (Type)

Lloyd A. Hoffman

22d. ADDRESS

214 N. Potomac St. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

4/17/62

23c. NAME OF CEMETERY OR CREMATORIUM

Rest Haven Cemetery

23d. LOCATION (City, town or county)

Hagerstown Wash Co Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Andrew K. Coffman Hagerstown Md.

ADDRESS

25a. REC'D BY REGISTRAR

APR 19 '62

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Traus

7A120

